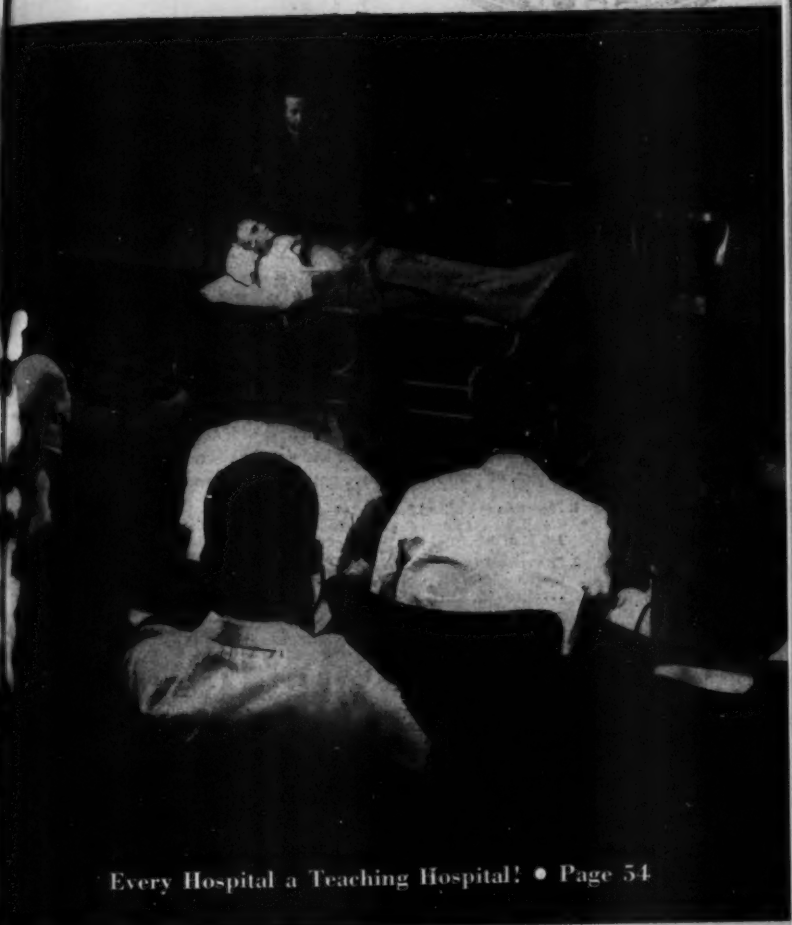
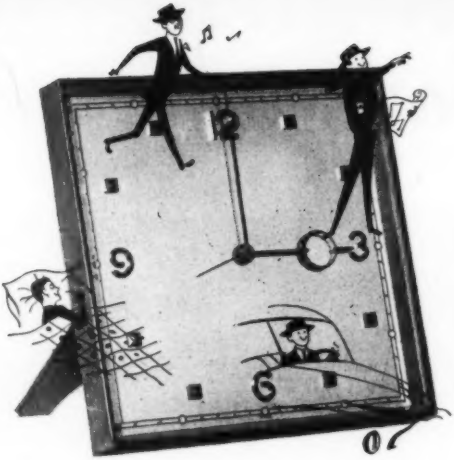
September

Medical Economics



Every Hospital a Teaching Hospital! • Page 54



For your allergic patients... the antihistamine that gives

'Round-the-clock relief from 4 small doses

Decapryn's *long-lasting relief*,[1] combined with *low milligram dosage*,[2] makes it the ideal antihistamine for treating difficult allergies, or patients who have not responded to other drugs.

1. "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—"... Sheldon, J.M. Et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948)
2. "It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—"... MacQuiddy, E.L.: Neb. State M.J. 34:123 (1949)

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Available on prescription only, as pleasant-tasting liquid, or tablets (12.5 mg., 25 mg.)

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Widespread acceptance of the Spencer Hb-Meter prove that physicians need this means of obtaining *laborato* accuracy in hemoglobin determination *in less than minutes.*

Only the Hb-Meter permits:

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CHICAGO, ILLINOIS

Medical Economics

* * * *September 1950* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

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The attractive new plastic case, hardly larger than a cigarette package, includes complete facilities for urine-sugar detection. Your diabetic patients, long accustomed to depend upon the rapidity, accuracy and convenience of *Clinitest* (Brand) Reagent Tablets, will find the new Universal Model (No. 2155), with optional tablet refills, handier than ever.

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BACK TO ACTIVITY is now a reality for many chronic asthmatics, thanks to an effective new bronchodilating powder. Called NORISODRINE Sulfate, the powder is supplied in multiple-dose cartridges, for inhalation therapy with the AEROHALOR. • The asthmatic simply inhales orally three or four times and the attack usually ends quickly. Effective against both mild and severe asthma, NORISODRINE has been proved by clinical investigation.[1,2] The drug is of relatively low toxicity. Proper administration results in few and usually minor side-effects. • Before prescribing this potent drug, however, please write to Abbott Laboratories, North Chicago, Illinois, for literature. This explains how to determine individual dosage and the precautions to be taken. NORISODRINE powder 10% and 25% comes in multiple-dose Aerohalor* Cartridges. AEROHALOR is prescribed separately.

*Trade Mark for Abbott Sifter Cartridge.

note the name

Norisodrine® *sulfate powder*

(Isopropylarterenol Sulfate, Abbott)

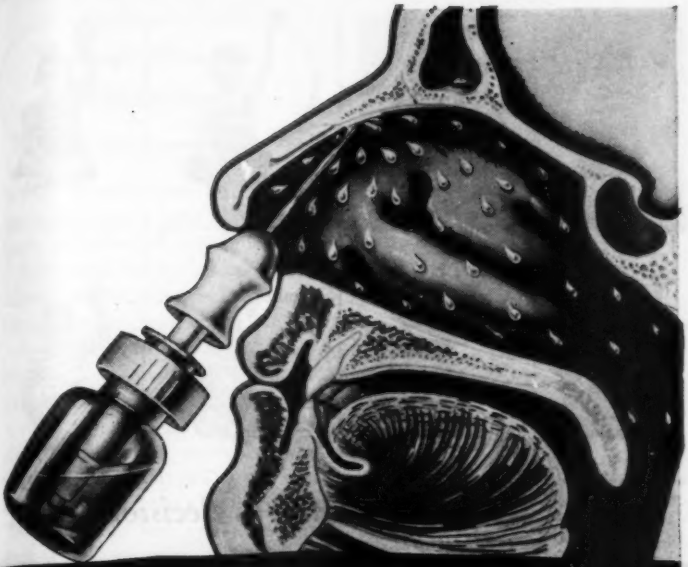
for use with the *Aerohalor®*

Abbott's powder inhaler

1. Krasno, L. R., Grossman, M. I., and Ivy, A. C. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March. 2. Krasno, L. R., Grossman, M. and Ivy, A. C. (1948), The Inhalation of Norisodrine Sulfate Dust, Science, 108:476, October 29.

always ready for use when the need arises

Abbott



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Solves the nose-drop problem with children.

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Since Eskadiamer is an aqueous suspension of microcrystalline sulfadiazine and microcrystalline sulfamerazine, desired serum levels are attained much more rapidly than with sulfonamide tablets of equivalent dosage.

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Eskadiamer *the delicious fluid preparation of sulfamerazine and sulfadiazine*

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Each 5 cc. (one teaspoonful) of ESKADIAMER contains 0.25 Gm. (3.86 gr.) microcrystalline sulfamerazine and 0.25 Gm. (3.86 gr.) microcrystalline sulfadiazine—the dosage equivalent of the standard 0.5 Gm. (7.7 gr.) sulfonamide tablet.

Memo from the Publisher

• Ever wonder how the dollars-and-cents side of your career compares with that of colleagues?

Ever need the names of reliable consultants in office management, group practice, and such?

Got an insurance, tax, or medico-legal problem on which you'd like the consensus of experts?

If so, you might like to hear about our reader's service department, which grapples with hundreds of such posers each month. We've already told you about the back-article requests it fills (see August issue). Here are some other things it has to offer:

Facts and figures. Perhaps, for example, you'd like to compare your collection percentage with the average for all independent practitioners (88 per cent). Or your investment in equipment with that of the average radiologist ($19,313). Past MEDICAL ECONOMICS surveys have yielded a bumper crop of these "yardstick" figures. Like almost everything else available through reader's service, they're yours at the drop of a penny postcard.

A more diverse assortment of facts is on tap in our information file—the largest of its type in the country, containing more than 100,000 clippings, releases, and reference reports. In one typical

day, we were able to tell inquiring letter-writers where to buy metal wallpaper for treatment rooms, how the Government's policy on Rx refills has changed, who gave Oscar Ewing his start in politics, and which entertainment costs count as income tax deductions.

Contact with authorities. If you want to get in touch with top experts in special fields—office design, public relations, time-saving techniques, anti-socialism, and more than a hundred others—our reader's service department may be able to help you. Its consultants' file is studded with names that have been added selectively over the years.

Research service. We don't profess to know all the answers. But *if* your query is important enough to doctors generally, it will be handed to a MEDICAL ECONOMICS staffer as a reportorial assignment. This often results in a full-length article based on brand-new research.

It was a reader's letter about unethical colleagues, for example, that set wheels in motion for our recent piece entitled "Ways to Curb the Fringe Physician." It was a reader's query about post-graduate training that touched off "Every Hospital a Teaching Hospital!" in this issue.

So reader's service is really a two-way street. You can get useful information; our editors can get fresh ideas for timely articles. That's why we're glad to have you keep the questions coming.

—LANSING CHAPMAN

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SKIN CLOSURE SUTURES

Complete Emergency Suture Assortment IN STERILE PACK JARS, READY TO USE

You don't waste time boiling tubes when you have the Surgiset. The germicide in the jars keeps tubes sterile.

Surgiset contains 3 dozen Atraloc eyeless needle sutures: 5-0 monofilament nylon on small cutting needle for facial repair; 3-0 dermal on medium cutting needle for normal skin repair; 2-0 dermal on heavy cutting needle for heavy skin.

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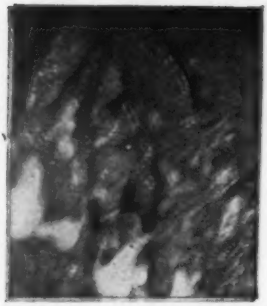
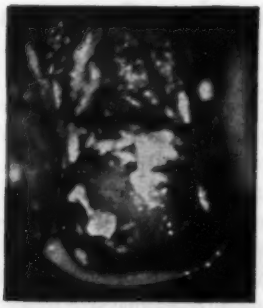
Trichomonal vaginal invasion is characterized by a profuse leukorrhea and disturbing pruritus. The discharge is usually foaming, saliva-like, thin and whitish, but may be thick, yellow and foul-smelling.



Vulvovaginitis (Mycotic)

Cervicovaginitis (Trichomonal)

Vulvovaginitis (Trichomonal)



Vaginitis (Mycotic)

Restore normal vaginal "chemistry"...

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"For some time we have enjoyed the best results by the use of Floraquin tablets. Two are inserted each night at bedtime, full finger length, followed by a saline douche each morning, ½ ounce to 1 quart of boiled water."

—Baer, J. L.: Office Gynecology, Wisconsin M. J. 48:504 (June) 1949.

Floraquin®—a product of Searle Research—helps restore the normal acid pH which resists vaginal infection, while simultaneously combating the offending pathogenic organisms. It supplies also the carbohydrates essential for the maintenance of the normal vaginal flora. Floraquin supplies the protozoacide, Diodoquin-Searle, with lactose, dextrose and boric acid.

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Floraquin Tablets—for patient's use.

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3 Questions every doctor is asked

1. "Which evaporated milk should I use in my baby's formula?"

When you answer "Carnation," you name the milk which has been approved by the medical profession for generations. And Carnation protects your recommendation by maintaining unsurpassed standards of safety, uniformity, and nutritive value. Every can of Carnation Milk is processed with "prescription accuracy" in Carnation's *own* evaporating plants... under Carnation's *own* strict supervision.

2. "Should I change to bottle milk when my baby goes off formula?"

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3. "How can I wean my baby from bottle to cup-drinking?"

Baby's natural resistance to change is increased if the cup contains milk with a strange new taste. And the use of a different form of milk can lead to digestive upsets. Doctors have found that the combination of Carnation's familiar flavor and uniform composition facilitate the weaning process... while its unsurpassed nutritional qualities encourage the uninterrupted healthy growth of the baby.

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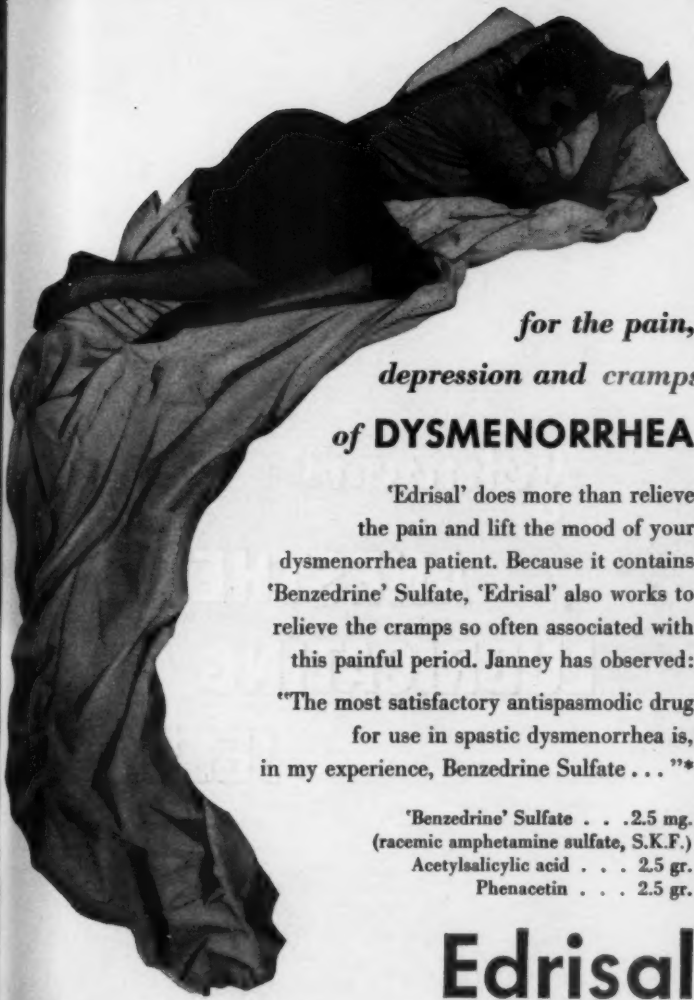
The Milk Every Doctor Knows



for the pain,

depression and cramps

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'Edrisal' does more than relieve the pain and lift the mood of your dysmenorrhea patient. Because it contains 'Benzedrine' Sulfate, 'Edrisal' also works to relieve the cramps so often associated with this painful period. Janney has observed:

"The most satisfactory antispasmodic drug for use in spastic dysmenorrhea is, in my experience, Benzedrine Sulfate . . . "*

'Benzedrine' Sulfate . . . .2.5 mg.
(racemic amphetamine sulfate, S.K.F.)
Acetylsalicylic acid . . . 2.5 gr.
Phenacetin . . . 2.5 gr.

Edrisal

Dosage: Two tablets, repeated every three hours, starting two days before menstruation. *Smith, Kline & French Laboratories • Philadelphia*

'Edrisal' and 'Benzedrine' T.M. Reg. U.S. Pat. Off.

*Janney, J.C.: Dysmenorrhea, Medical Gynecology, Philadelphia, W.B. Saunders, 1945.


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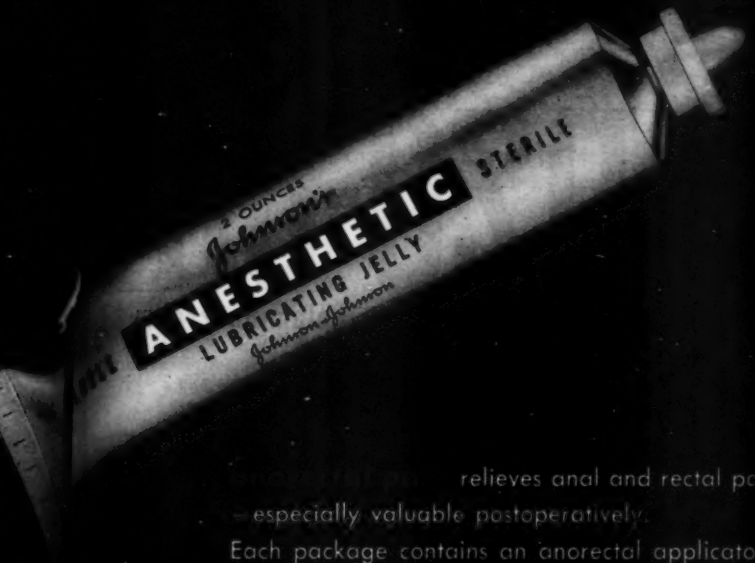
combined anesthetic-lubricant
action facilitates cystoscopy, proctoscopy
and other endoscopic procedures.



relieves anal and rectal pain
especially valuable postoperatively.
Each package contains an anorectal applicator.

protective anesthetic dressing for
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in itching, irritative skin conditions... to soothe, protect, aid healing... stop scratching... reduce risk of infection

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Name_____ M.D., Address_____

Panorama

Breaking into professional association offices becoming a habit. First the AMA Chicago office in Feb. 1949; then the American Nurses Association New York office in July 1950. Again, no theft of valuables, but diligent ransacking of files—especially in room of a recent ANA committee head alleged to have had Communist ties. Whodunit? . . . Record-breaking $30 million raised this year by national polio foundation shrinking fast; late 1950 emergency drive now being rumored.

Operating expenses of 90 Blue Cross plans in first quarter of 1950 averaged only 8 per cent of income . . . Life annuity of $100,000 a year would be divided among discoverers of "general cures" for polio, heart disease, and cancer, under terms of H.R. 8815, introduced by Rep. Phil J. Welch (D., Mo.) . . . Puzzle: Why did Senator H. Alexander Smith (R., N.J.), arch foe of Truman health program, nominate Dr. Dean A. Clark to investigate Blue Cross-Blue Shield plans for Senate health subcommittee? Clark, long on outs with medical societies in New York City, bucked local Blue Shield with his controversial Health Insurance Plan (HIP).

English surgeons prefer to be called "Mister," not "Doctor." One of them, on golf course recently, was hailed by an acquaintance with "Good morning, Doctor!" Surgeon cut back: "Good morning, wholesale manufacturer of boots and shoes!" . . . Thousand copies of John T. Flynn's "The Road Ahead" placed in hospitals by New York State Medical Society, which will distribute more if public shows interest . . . AMA rapping knuckles of medical organizations that ignored invitation to White House Conference on Children and Youth, to be held in December . . . Twenty-seven of 37 state medical societies

reporting say they now have facilities for handling grievances . . . New American Academy of Forensic Sciences organizing its sections: pathology, psychiatry, toxicology, immunology, jurisprudence, police science, and questioned documents. Third meeting will be held early in 1951 in Chicago, says secretary-treasurer, Prof. Ralph F. Turner, Michigan State College, East Lansing, Mich.

Twenty-nine per cent of Americans would advise a youth to pick medicine as career, while 16 per cent would suggest engineering, Gallup Poll reports. Other vocations—business, law, ministry, etc.—got 8 per cent of votes apiece, or less . . . Dr. Clarence A. Smith, Seattle, Wash., 90 next Jan. 21, just celebrated 60th wedding anniversary and 47th year as editor of Northwest Medicine . . . "How stuffy can you get?" asks New York Daily Mirror of medical societies. Long a foe of nationalized medicine, newspaper commissioned an M.D. to write health articles, then found "ethics" forbade use of his name. Mirror will continue opposition to Truman plan, but says it hates "to get kicked in the teeth" for its pains.

Latest Public Health Service project: an Arctic Health Research Center at Anchorage . . . Emergency phone numbers of Denver (Col.) Medical Society and of local police and fire departments are inscribed on plastic discs distributed to Denverites for installation on dial phones . . . "What a Difference a D Makes," sings Detroit Medical News, having come upon this surgical report: "Patient was placed in the lithotomy position, prepared with soap and water, and raped in the usual manner."

Government's non-secret atomic data available at last to medical researchers in 31 libraries throughout country . . . Sitting pretty: Little Yankee Inn, Geneva, Ill., where physically and mentally healthy kids with parents sick or away can now be accommodated in style. Strictly a hotel for well children—not a hospital—inn is run by an R.N., supervised by Geneva pediatrician Robert H. Sykes. Guests (2 weeks to 6 years old) must be referred by doctor, certified in good health.

EIGHT PULLING TOGETHER

ABDEC® DROPS

ABDEC DROPS
Each 0.6 cc. represents:

Vitamin A 5000 units
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The average daily dose for infants under one year is 0.3 cc. (5 minims); for older children, 0.6 cc. (10 minims). A special dropper, graduated at 0.3 cc. and 0.6 cc., is supplied with each package to facilitate accurate dosage.

ABDEC DROPS: 15 and 50 cc. bottles with graduated dropper.

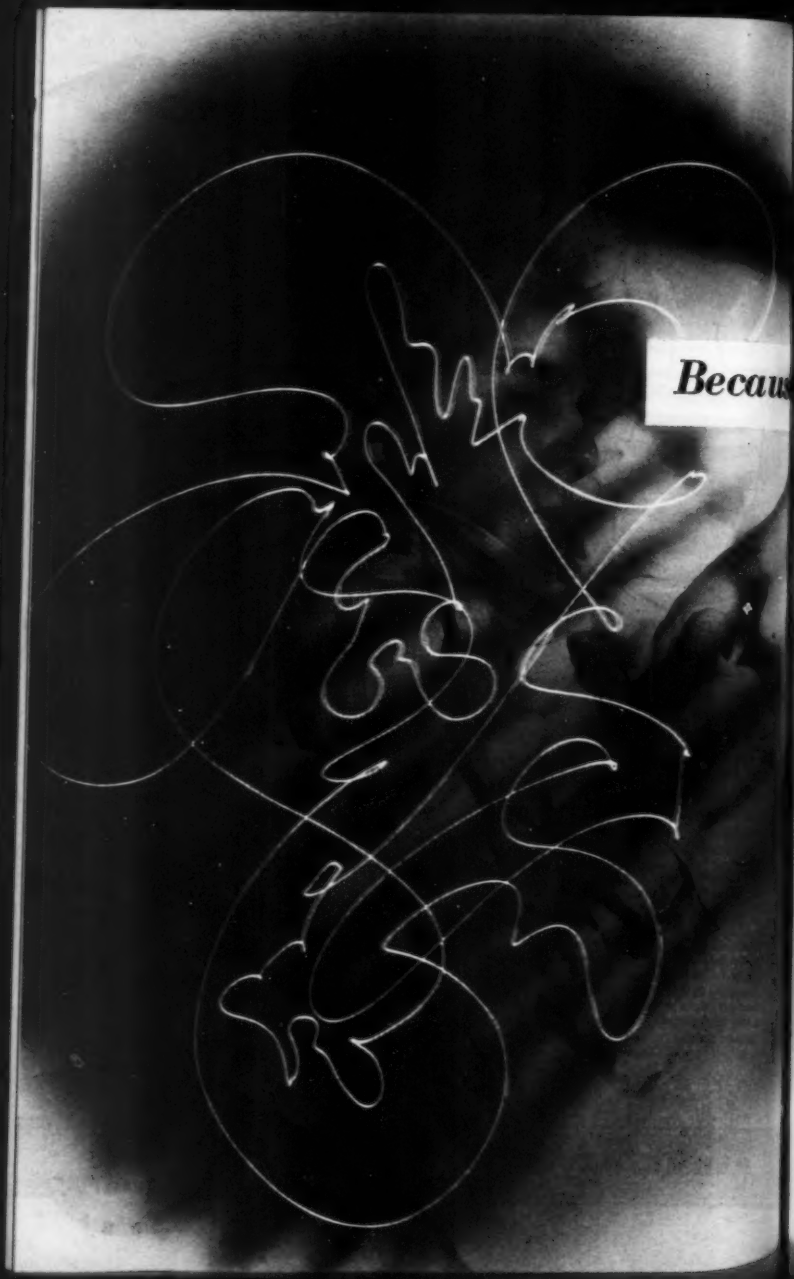
For strong healthy bodies optimal nutrition in infancy and childhood is of the utmost importance. A bountiful vitamin intake . . . cornerstone of good nutrition . . . is assured by the routine prescribing of ABDEC DROPS for *regular* prophylactic administration to *all* pediatric patients.

ABDEC DROPS provide eight important vitamins, both of water-soluble and of fat-soluble groups, in a stable non-alcoholic vehicle. High concentration of vitamins permits small, easily managed doses, readily measured by the calibrated dropper accompanying each package.

Freely miscible with milk, fruit juices, cereals, and soups, ABDEC DROPS may conveniently be administered in food without impairment of taste or appearance. They are also readily accepted directly on the tongue by most children.

Uniformly potent . . . clinically dependable . . . ABDEC DROPS are ideally suited to the multivitamin requirements of the young.

PARKE, DAVIS & COMPANY



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"SLEEP OFF" *hypertension...*

prolonged vasodilation should accompany sleep as well as the day's activities. (One more reason why NITRANITOL is the most universally prescribed drug in the management of hypertension.)

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FOR GRADUAL, PROLONGED, SAFE VASODILATION

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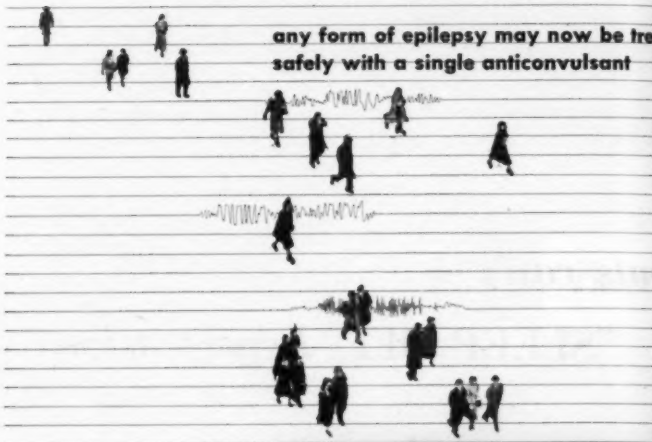
When vasodilation alone is indicated. *Nitranitol.* (½ gr. mannitol hexanitrate.)

When sedation is desired. *Nitranitol with Phenobarbital.* (½ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

For extra protection against hazards of capillary fragility. *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

When the threat of cardiac failure exists. *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ½ gr. Phenobarbital and 1½ grs. Theophylline.)



any form of epilepsy may now be treated safely with a single anticonvulsant

THIANTOIN SODIUM

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No longer is it necessary to run the risk of bringing a second type of seizure into prominence by the selection of a limited anticonvulsant.

'Thiantoin Sodium' is a more widely useful antiepileptic and is far safer than related drugs of comparable potency. Many resistant cases are controlled with doses which have been elevated safely to levels that were previously unattainable.

Not only are there fewer side-effects, but there is often striking improvement of mental function in epileptic patients who receive 'Thiantoin Sodium.'

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Complete literature on 'Thiantoin Sodium' is available from your Lilly medical service representative or will be forwarded upon request.

Speaking Frankly

Citation

The article by Francis F. Borzell in your June issue and similar articles appearing in MEDICAL ECONOMICS from time to time, have been of inestimable help in explaining the work of the American Medical Association.

Such constructive assistance plays an important role in the battle against the socialistic trend being urged in our nation by a few would-be bureaucrats who have not the people's health and welfare honestly at heart.

Editorial policies which recognize the importance of this problem, both to the medical profession and the nation as a whole, deserve commendation and support. And any article that fairly presents the facts is of interest to and should be read by all members of the medical profession.

To you and your colleagues I would like to express my personal appreciation of your valuable support in medicine's fight for freedom.

E. L. Henderson, M.D., President
American Medical Association

Dues

Now there's a *new* racket!

Every hospital in my vicinity is writing courtesy-staff members thus: "Your dues have not been paid. Unless they are, you will be dropped from the staff."

This despite the fact that the doctor has to pay dues and assessments to the AMA, as well as to state and county societies, to be recognized by these hospitals.

If the hospitals are in such desperate straits, isn't it about time to ask for a Federal subsidy, instead of loading extra financial burdens on the medical profession?

M.D., New Jersey

Yum

Caviar to you for exposing, in your June Panorama department, the indefensible action of the Hospital Council of Greater New York in opposing New York State legislation clarifying the practice of roentgenology [by prohibiting anyone but an M.D. from explaining what an X-ray picture shows].

Relying on the Sausser decision (150 NE 603), which exhibited neither a knowledge of the role of diagnosis in medicine nor of roentgenology in diagnosis, they have acted to defeat a law long supported by the medical profession. This obstructionism is motivated entirely by a desire to restrict the rec-

ognition of the radiologist and to control the practice of medicine. The HCGNY is to be soundly condemned for betraying the best interests of the patient-public.

William C. Stronach, Exec. Secy.
American College of Radiology
Chicago, Ill.

Democracy

Prompted by your June editorial, "Democracy in Medicine," I enclose a ballot of the Chicago Medical Society, as used in its 1950 elections.

Note that for each office (president, vice president, secretary) only one name appears on the ballot and that no space is provided for write-ins. Note also the ironic instruction, in each case, to "vote for one." For councilors-at-large, and again for alternate councilors-at-large, five names appear, with the instruction to "vote for five."

It would be interesting to know what percentage of Chicago Medical Society members bothered to vote at all.

M.D., Illinois

Congratulations on the splendid article on the late Dr. Charles R. Drew, in your May issue. It is regrettable that an American surgeon, certified by the American Board of Surgery and a Fellow of the International College of Surgeons, whose pioneer work in the preservation of blood plasma is credited with saving hundreds of American lives in World War II, could not secure membership in the American Medi-

the least toxic sulfonamide studied*

Yes, SULFACETAMIDE . . . the least toxic sulfonamide reported in Lehr's clinical studies . . . is now combined with sulfadiazine and sulfamerazine as Pansulfa, with these therapeutic advantages:

1 The established antibacterial power of three sulfas.

2 Less danger of crystalluria or renal damage.

3 Uniform dosage—the thixotropic gel of the suspension assures even dispersion. Also available in palatable tablets.

Pleasant tasting

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SULFADIAZINE
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Each teaspoonful or tablet contains 0.5 Gm. (7½ gr.) of the rapidly soluble sulfonamides 1:1:1

*Lehr, D. Federation Proc. 8:315 (1949)

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cal Association. I am sure your readers can decide for themselves whether the AMA is a truly democratic organization.

A. A. Phillips, M.D.
Newark, N.J.

AAGP

MEDICAL ECONOMICS DESERVES NOT ONLY CONGRATULATIONS FOR A DISCERNING APPRAISAL OF THE AMERICAN ACADEMY OF GENERAL PRACTICE IN ITS JUNE ISSUE, BUT A SPECIAL KUDO FOR THE EXTRAORDINARY PRESCIENCE REVEALED IN THE EXCERPT FROM ITS DECEMBER 1940 ISSUE. FAITHFUL ADHERENCE TO THE PRINCIPLES AND OBJECTIVES ANTICIPATED BY MEDICAL ECONOMICS TEN YEARS AGO HAS GAINED FOR THE ACADEMY A CONSPICUOUS POSITION IN THE CITADEL OF MEDICINE.

Mac F. Cahal, Exec. Secy.
Amer. Acad. of General Practice
Kansas City, Mo.

Secret

In your June issue, "M.D., New Hampshire" writes: "In time of war, physicians who enter the armed forces have top priority in getting secret information." This is absolutely incorrect.

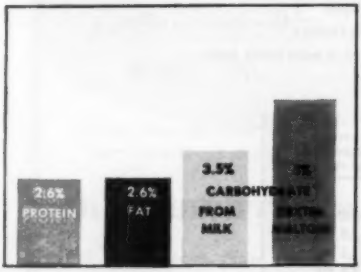
Army Regulations specifically state that no person by virtue of his commission or rank has any right of access to any classified document that does not pertain to his particular job. Comparatively little secret information is normally seen by any medical officer, unless in a very high position, and then only when necessary to his job. The average med-

MEAD'S

two new evaporated milk and Dextri-Maltose formulas

LACTUM

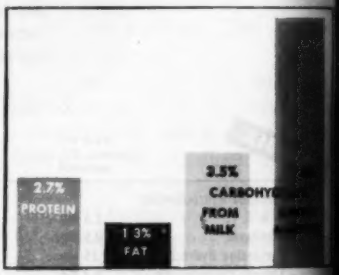
is a whole milk and Dextri-Maltose® formula based on average nutritional needs of full term infants.



Lactum in 1:1 dilution. 20 calories per fl. oz.

DALACTUM

is a low fat formula designed for bot premature and full term infants wit low fat tolerance; excellent also fo babies that are weak, malnourished, convalescent or febrile.



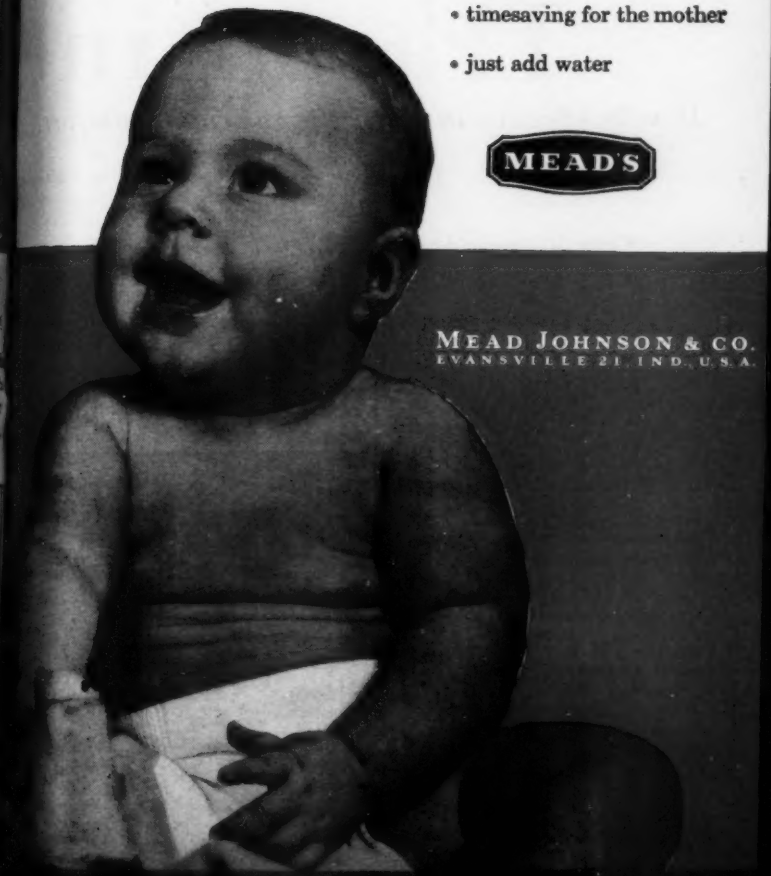
Dalactum in 1:1 dilution. 20 calories per fl. o

*Sufficient Dextri-Maltose is added to both Lactum and Dalactum to make the caloric value adequate. Because of its lower fat content, Dalactum contains more carbohydrate than Lactum.

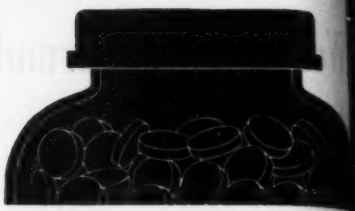
Well balanced formulas...simple to use

- generous in protein
- nutritionally sound
- uniform in composition
- safe for the baby
- timesaving for the mother
- just add water

MEAD'S



MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U.S.A.



NEW!

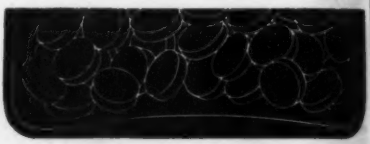
Carmethose-Trasentine

Doubly effective in relieving gastric discomfort...

Carmethose-Trasentine is a logical combination of a new *antacid* and an effective *antispasmodic* to control gastric discomfort.

Controls hyperacidity . . . This combination lowers gastric acidity and forms a protective coating which has been observed in the stomach for as long as three hours.

Controls spasm . . . Carmethose-Trasentine relieves gastric pain also by relaxing smooth muscle spasm. The anesthetic effect of Trasentine further controls gastric irritability. Carmethose-Trasentine is non-constipating, palatable and eliminates acid-rebound.



Issued: Carmethose-Trasentine Tablets: sodium carboxymethylcellulose, 225 mg.; magnesium oxide, 75 mg.; Trasentine, 25 mg. Bottles of 100.
Carmethose without Trasentine is also available for use in cases where the antispasmodic component is considered unnecessary. Available as Tablets, each containing sodium carboxymethylcellulose 225 mg., with magnesium oxide 75 mg., and as Liquid, a 5% solution of sodium carboxymethylcellulose.

Ciba *Pharmaceutical Products, Inc.,*
Summit, N. J.

CARMETHOSE T.M. (brand of sodium carboxymethylcellulose)
TRASENTINE ● (brand of adiphenine)

Actual photograph of an omentum. It is grossly thickened with increased fatty deposits. Pathologist's diagnoses: "obesity; left ventricular hypertrophy; pulmonary edema and congestion; fatty infiltration of liver; fatty infiltration of pancreas."

The omentum of an overweight patient

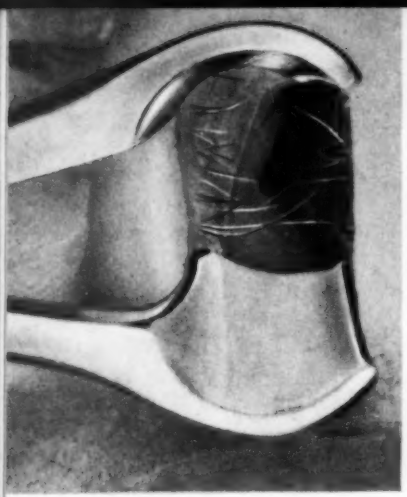
Weight reduction—of even a few pounds—is often the surest means of lengthening life and diminishing future illnesses.

'Dexedrine' Sulfate curbs appetite, makes it easy for the patient to adhere to a low-calorie diet and thus to reduce weight safely—without the use (and risk) of such potentially dangerous drugs as thyroid.
Smith, Kline & French Laboratories, Philadelphia

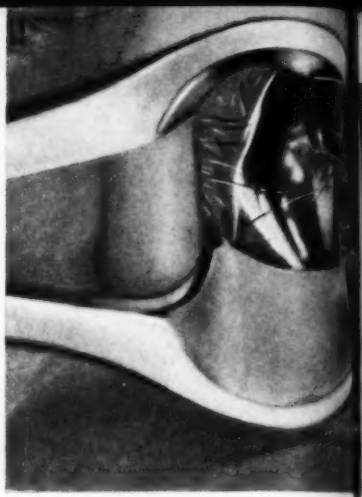
Dexedrine* Sulfate tablets • elixir

the most effective drug for control of appetite in weight reduction

*T.M. Reg. U.S. Pat. Off.



Before intranasal administration of Paredrine-Sulfathiazole Suspension.



After instillation of the Suspension in the Proetz—or head-low—position.

(Photographs slightly enlarged.)

New photographs show the advantages of a SUSPENSION in treating INTRANASAL INFECTIONS

Paredrine-Sulfathiazole Suspension—unlike antibacterial agents in *solution*—does not quickly wash away. It clings to infected areas for hours—assuring prolonged bacteriostasis. When instilled in the Proetz position, it reaches *all* of the sinal ostia, thus helping to prevent sinusitis.

Paredrine-Sulfathiazole Suspension is the most widely prescribed sulfonamide nose drop. No instances of sensitivity to its use have ever been reported.

Smith, Kline & French Laboratories, Philadelphia

Paredrine-Sulfathiazole Suspension

Vasoconstriction in Minutes . . . Bacteriostasis for Hours

'Paredrine' T.M. Reg. U.S. Pat. Off.

NEUTRALIZATION? *Yes*

GASTRIC INTERFERENCE? *No*

AND THE ANTACID WITH THE RIGHT ANSWERS IS *Al-Caroid*

It assures neutralization of excess acidity without retarding gastric digestion – in other words, it is both a gastric antacid and digestant.

This double-duty effect of Al-Caroid is best explained by its formula of fast-acting and slow-acting antacids as well as its "Caroid" content. The combined antacids provide a quick rise in pH values and give sustained relief at the same time. "Caroid" acts as a potent proteolytic enzyme.

TABLETS – bottles of 20, 50, 100, 500 and 1000.

POWDER – in 2 oz., 4 oz., and 1 lb. packages.

AL-CAROID antacid-digestant

send for literature and trial supply

American Ferment Company, inc., 1450 Broadway, New York 18, N. Y.

ical officer will see fewer secret documents than anyone else in the service.

John H. Schaefer, Colonel
Medical Corps, USAR
Los Angeles, Calif.

Quacks

Re "Gullible's Travels," the exposure of quackery in your June issue:

I could cite many instances of equally culpable and ambitious general practitioners.

What about the M.D., for example, who collects for X-rays and ECG's he doesn't know how to read? Or has fancy and expensive equipment merely to impress the patient and charge a higher fee? Or gives a series of injections for almost all ailments? Or makes a cardiac neurotic out of everyone with a murmur?

An enterprising reporter could turn up quite a story.

M.D., New Jersey

Specialism

"M.D., Texas," the has-been G.P. who is now a specialist, advises us to weigh the quality of general medicine against specialized medicine by asking "the average practitioner where he goes when he or his family is ill."

Naturally when one doctor consults another—for himself or for a member of his family—he tends to go to a specialist. But only because the first doctor has already done everything within his own knowledge. In other words, *he* consults a specialist for the same reason he

sends a *patient* to a specialist.

Further, for every time a G.P. has to take himself or a family member to a specialist, the same G.P. has probably treated himself or his family a hundred times—and successfully.

As long as patients are told that G.P.'s are "not qualified," or that specialists are "over-zealous," the public will continue to be confused. It is the doctors' responsibility to define the line where general practice stops and specialty practice begins. The answer is not for the specialist to take over what the G.P. can and does do, but to achieve a training and ability so far beyond the G.P. that no competition exists.

We have several men of that caliber here in Austin. They not only feel that the best medicine stems from having a G.P. see the patient originally, but they refuse to treat a patient who can be treated by a G.P. Further, they are happy to teach the G.P. anything he cares to know relating to their fields. They know so infinitely more about those fields than does the G.P. that they don't *have* to steal patients.

Harold L. Robinson, M.D.
Austin, Tex.

I know of many instances where a specialist, with illness in his family, has called in a G.P. Many a G.P. in the same boat would call in another G.P. if it weren't for competitive reasons. He fears it might show a lack of confidence in himself to consult someone on his own "level." The situation may also be compared

to that of the surgeon who goes to a distant clinic for his cholecystectomy rather than have his home town competitor take the glory for the job.

Many G.P.'s treat their own family members on the same basis as other patients, referring them to specialists as the need arises. If such referrals are frequent, it is because the average physician does not care to assume the responsibility of caring for his loved ones.

John G. Walsh, M.D.
Sacramento, Calif.

Mates

May I suggest a series of articles on husbands and wives in medicine?

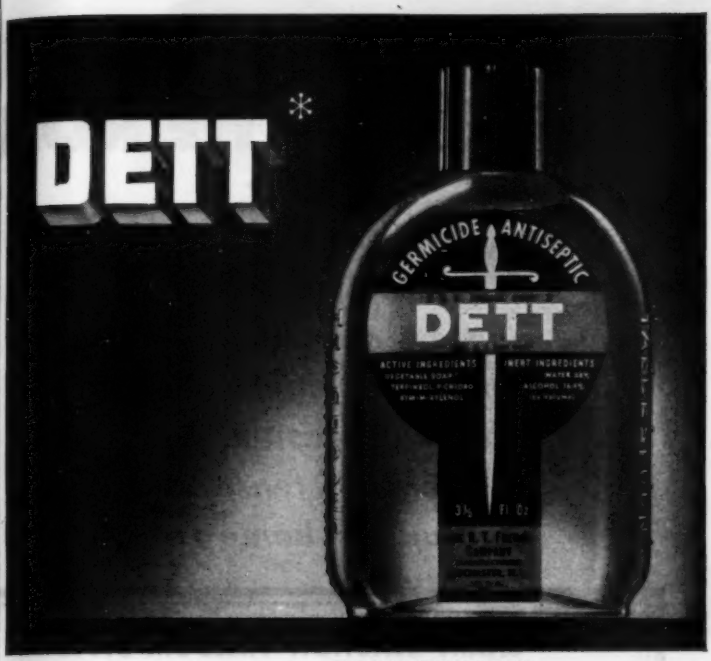
M.D., Indiana

With help from other readers, MEDICAL ECONOMICS *will be happy to present an article about interesting medical mates. Nominations are now open. Send in the names of your candidates. Each must of course be a practicing M.D.*

Old-Fashioned

Your recent article, "Euthanasia Society Exploits News," was terrifying! Thank God that only a few members are of the medical profession! It may be an old-fashioned idea, but I have always thought a doctor should combine the virtues of ethics, compassion, and morality. Euthanasia calls for none of these. It is premeditated *murder!*

E. H. Leggiadro
Port Chester, N.Y.



*ALSO KNOWN AS DETTOL

A "new" Antiseptic proved by 20 years performance

New to the medical profession of the United States, Dett, under the name Dettol, is standard equipment for surgeons and hospitals throughout the British Empire. Dett, for obstetrical and surgical use, has been proved since 1929.

Dett, although deadly to germs, is gentle to human tissue. This clean, clear liquid with an agreeable odor is safe, effective, non-irritating and non-staining. Physicians who have used Dettol in other countries will welcome its introduction in the United States under the name of Dett.

For a generous size sample, and literature, write to: The R. T. French Co., Pharmaceutical Department, Rochester 9, New York.

DETT *THE MODERN WEAPON AGAINST INFECTION*

A Message to Medical Advertisers:

HELP CALL THE ROLL

At a time when Americans are defending freedom from aggressive outside attack, the doctors of America believe it is the occasion, too, for outspoken defense of freedom on the home front.

CHAIN REACTION—FREEDOM STYLE

Already tens of millions of Americans—through more than 10,000 publicly responsible organizations — are on record against Government Compulsory Health Insurance.

But Socialized Medicine—the proven forerunner of a completely Socialized State—remains an active enemy of the American Voluntary System. American doctors believe the Voluntary Way is the American Way to solve problems of medical care, cost and service. And America's world leadership in medical affairs proves that conviction!

As a spearhead in the battle for freedom, the medical profession will spend $1,000,000 in October through news-

For information about your tie-in advertising, address:

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FOR FREEDOM!

papers, magazines and radio—to send that message to every citizen in every community in the Nation.

During the week of October 8, a 70-inch advertisement carrying medicine's statement will appear in every daily and weekly newspaper of paid general circulation—regardless of editorial position. Representative National magazines, and radio stations in every State, will carry the same message in October.

LET FREEDOM RING!

Every friend of economic, social and political freedom for America **is invited to participate in the Freedom Roll Call —to speak out for freedom with advertising messages of his own—to swell the great public testimonial that—**

The Voluntary Way is the American Way!

National Education Campaign
AMERICAN MEDICAL ASSOCIATION
Chicago 2, Illinois

Ruggedness plus

Set it down . . . pick it up . . . move it around! The Rouy-Photrometer *stays* accurate under the hardest usage. Equipped with a compensated *microammeter*, it gives a steady, unwavering reading at all times, regardless of vibrations and other conditions which ordinarily might affect the accuracy of the indicating needle.

Accuracy

—Careful matching of its photoelectric cell and microammeter make the Rouy-Photrometer the most highly accurate photoelectric colorimeter available, cutting inherent functional error to less than 0.1%. Optical system is designed to eliminate possibility of stray light with attendant error. As a further safeguard for accuracy, parts are *locked in place* to prevent misalignment.

Simplicity

—The Rouy-Photrometer eliminates calculation and the need for preparing standards, as it is *pre-calibrated* for **40** common clinical tests. Any competent worker can operate the Photrometer, obtaining *instantaneous* readings with amazing ease. There is a single control for all adjustments, and an accompanying Handbook contains outlines of standard clinical methods and a calibration table for each.

Selectivity

—Eleven narrow band filters cover the spectrum from 415 to 640 millimicrons. One blank space is provided for special filters. The photoelectric cell and microammeter for each Photrometer are carefully selected and tested for utmost sensitivity and reproducibility.

ROUY-Photrometer

by Leitz

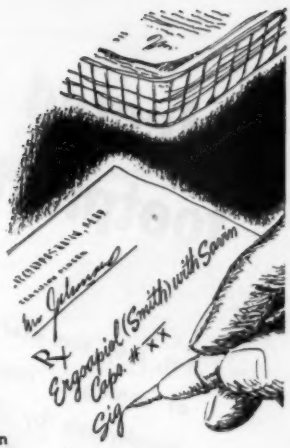
Pre-calibrated for 40 tests—$257.80
Pre-calibrated for 22 tests—$182.80

For a demonstration, see your franchised Leitz Dealer or write Dept. E

E. LEITZ, Inc., 304 Hudson Street, New York 13, N. Y.

LEITZ SCIENTIFIC INSTRUMENTS • MICROSCOPES • LEICA CAMERAS AND ACCESSORIES

Only on your Rx . . .



When prescribing Ergoapiol (Smith) with Savin for your gynecologic patients, you have the assurance that it can be obtained only on a written prescription, since this is the only manner in which this ethical preparation can be legally dispensed by the pharmacist. The dispensing of this **uterine tonic**, time-tested ERGOAPIOL (Smith) WITH SAVIN —only on your prescription—serves the best interests of physician and patient.

INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.

GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.

In ethical packages of 20 capsules each, bearing no directions.

ERGOAPIOL (SMITH) WITH SAVIN

Literature Available to Physicians Only.

Ethical protective mark, M.H.S., visible only when capsule is cut in half at seam.

MARTIN H. SMITH COMPANY
350 Lafayette Street • New York 13, N. Y.

Sidelights

Fee Setting

On the way home from his office last month, a physician we know stopped at a plumbing-and-furnace supply place to see about having another fuel-oil tank installed in his cellar. This spring he'd checked tank prices and found the 275-gallon size generally quoted around $30. Now the dealer told him the price was $60—*if* he could get one for him.

Our colleague, in a fine huff, drove home.

After dinner he made a house call. The patient required penicillin, which the doctor administered. Altogether, the charge was $8 ($5 for the call, $3 for penicillin).

There had been a growing tendency among some physicians in the community to make this extra $3 charge for penicillin injections. Up until now our friend had scorned the practice on grounds that the stuff cost only 60 cents and that charging $3 for it was profiteering. But, as he heatedly explained to us a few days later, if he was going to be victimized by those dirty war gougers, why, by George, a man had a right to protect himself.

We didn't agree with his reasoning but we did share his resentment against the gougers. We'd like to be able to report, therefore, that the patient who got stuck for the $3 penicillin charge was the plumbing-and-furnace dealer. He wasn't, though. Just an innocent third party.

Wartime Injustices

Some 50,000 M.D.'s served with the armed forces in the last war. The majority gave up established practices to do so.

For nearly all, return to civilian life involved problems: office and equipment problems, re-education problems, patient problems, personal psychological problems. Many of the men were just plain browned off: at the rest of the profession, at the military system they'd been a part of, at the world in general. All were years older, nearly all were poorer in both skill and money.

Much of this was inevitable. Yet some of it was avoidable. War is shot through with inequities, for physicians and everyone else. That some people get rich and others ruined isn't the most outrageous of these. After all, some get killed, others don't.

But, granting all that, can't a great deal still be done toward

minimizing war's injustices? Can't medicine, the most highly organized of the professions, guarantee its members who go this time a better break than those who went last time?

The issue demands the most careful study. And now is not any too soon to begin.

History-Taking

These days, the doctor's aide seems to be taking more and more of the patient's clinical history. Recording the chief complaint, past illnesses and operations, etc. is held to be mainly a clerical job—one not worthy of the physician's time. We disagree.

We know a good many people who resent being quizzed by the doctor's secretary—particularly if she tries to get the job done in an exposed corner of the reception room. Besides, such histories tend to be inaccurate. Most girls have neither the training nor the tact to draw out all the essential facts needed for diagnosis.

Of course, there's plenty of form-filling the girl in the anteroom can help with. But the heart of the clinical history, it seems to us, is something for the doctor alone.

Market Master

We dropped in recently on a practicing physician in Manhattan who's reputed to be quite a man about Wall Street. Our idea was to pick

RELAX THAT SPASM

with MESOPIN

When pain, heartburn, belching, nausea, or unstable colon are due to gastrointestinal spasm, Mesopin provides an effective means for prompt relief. Its selective antispasmodic action on the digestive tract controls spasticity without the undesirable side effects of atropine or belladonna. Thus, symptomatic relief of many common disturbances of the stomach or intestines can be achieved with discrimination and safety. Mesopin is indicated for the relief of gastrointestinal spasticity, such as pylorospasm, cardiospasm, spastic colon, and biliary spasm.

MESOPIN (brand of homatropine methyl bromide)

SELECTIVE GASTROINTESTINAL ANTISPASMODIC

SUPPLY: Elixir in 16 ounce bottles; tablets in bottles of 100.
MESOPIN (homatropine methyl bromide)—2.5 mg. per teaspoonful of elixir or per tablet. Also supplied: MESOPIN-PB*—2.5 mg. Mesopin and 15 mg. (1/4 gr.) phenobarbital per teaspoonful of elixir or per tablet.

Detailed literature and samples on request.

Endo®

*PB abbreviated designation for phenobarbital.

ENDO PRODUCTS INC., RICHMOND HILL 18, NEW YORK

up some pointers for other doctor-investors, perhaps a hot tip or two for ourselves.

Dr. Q, we'll call him, proved a voluble source. Soon our mind was agog with stock splits and leverage factors. For some three decades this M.D. has been jousting with the ticker tape, and he gave us to understand that things had turned out very, *very* well.

Prerequisites for Investors

"There's nothing mysterious about trading successfully in the market," he said between calls to his broker, "but there *are* several prerequisites. First, it's helpful to live in a big city, where you can make personal contacts with well-informed businessmen. Second, you should be deeply interested in finance. Finally, you must be willing to devote hours of study to investment problems every day of your life."

His father, we learned, was with one of the larger New York banks, and ever since the doctor could remember he had been exposed to parental talk about investments. Long before he learned about women he had the lowdown on puts and calls.

As a young man he visited Germany after World War I, watched enchanted as two of his traveling companions cleaned up in German stocks during the Reich's then rampant inflation. Back home, he lost no time selling the conservative bonds in which he'd invested his inheritance, and he hasn't made the

CHECK these two points when you prescribe a support:

1. That the support is so designed that it will NOT press downward on the abdomen.

   (A support that pulls downward against the abdomen INCREASES downward displacement of organs and places pressure on spine.)

2. That the support is so designed that it will NOT stretch out of shape.

   (A support that loses its shape, loses its effectiveness AND MAY BE HARMFUL RATHER THAN HELPFUL.)

Spencer Supports check on *all* points — *because:* Each Spencer is *individually designed, cut, and made* for each patient; each is guaranteed NOT to lose its shape (and to our knowledge is the only support so guaranteed); each is so designed that abdominal support is from below, upward and backward, paralleling the natural pull of abdominal muscles. Thus, muscle exercise is encouraged to help nature improve tonus.

In a Spencer the strain of supporting the abdomen is placed on pelvis, not on spine at or above lumbar region.

MAIL coupon at right—or PHONE a dealer in Spencer Supports (see "Spencer corsetiere," "Spencer Support Shop" or Classified Section) for information.

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individually designed SPENCER SUPPORTS®

mistake of buying one since.

"I rode the bull market to its top in 1929, then went short until 1932," he said casually. Diving into his wallet, he came up with brokerage slips to show how he'd been short of AT & T. We didn't see any money in the wallet and assumed he carried it in a satchel. "I was on the long side of the New Deal price rise, but got out just ahead of the big setbacks in '33 and '37."

We thought this was pretty fascinating stuff, and said so. "How'd you know enough to get out in 1929, Doctor?"

Cornucopia

Seizing a prescription pad, he drew a long, graceful up-curve. "That's how stocks looked in '29." Then he drew a down-curve. "And there you have bond yields." He connected the ends of the two curves so that they resembled a trumpet. "A horn, you see? As a banker friend of mine remarked at the time, that horn was blowing loud enough in '29 for any fool to hear. It was blowing: 'Get out of stocks!' "

"Wasn't it also blowing in 1928, Doctor?"

"But not so loud," he smiled, enigmatically. "Not so *loud*."

In training his ear for market fluctuations, Dr. Q has for years followed a strict daily regimen. He gets up half an hour early to scan the financial pages of the New York Times. Now and then throughout the day he's in phone touch with banking, business, or economist friends, and generally lunches with them. Many of his patients are corporate executives; he pumps them for the latest dope on their companies' earnings. Every evening he spends at least two hours poring over investment literature. He seldom misses any important New York meeting of economists, bankers, or other market-minded groups.

Tips for Rookies

Parlous as the future might seem for M.D.-investors less at home in the market than he, Dr Q believes they can and should invest in stocks. Only through equity shares, he believes, can the average physician build up an adequate retirement fund. Some 85 per cent of the population at age 65, he says, are dependent on relatives, friends, or charity for support, presumably because they didn't understand the stock market. Dr. Q's success formula for the uninitiated:

¶ Stick to blue chips and growth industries—utilities, chemicals, oils.

¶ Make use of dollar averaging,* an automatic savings-and-stock-purchase scheme that eliminates the problem of market-trend forecasting.

¶ Don't buy on margin.

With all this, how can he give proper attention to his patients? We figured it would be boorish to ask, so we checked the impulse.

*See "Investment Trusts: How They Buy and Sell," Nov. 1949 issue.

Nisulfazole does not cure Chronic Ulcerative Colitis!

• This new, specialized sulfonamide does raise to a higher standard the chemotherapeutic aspect of the "truly miserable affliction."

A recent finding has been advanced as the immediate cause of nonspecific ulcers in the colon. If sustained, this engaging concept will remove much of the unruliness of the disease; the unpredictability of treatment.

Meanwhile the proven facts have led clinicians to say that "Nisulfazole has given better results than any therapy previously used." And "its efficacy in controlling the active stages of ulcerative colitis is unquestioned.'

Nisulfazole (paranitrosulfathiazole) carries a nitro radical on its benzene nucleus. It is easily administered directly into the colon, to act locally. It does not enter the circulation significantly; no systemic toxicity is seen, even though administration is continued.

Nisulfazole®

10% Suspension

is supplied in wide mouth bottles of 296 cc (10 fl. oz.)

George A. Breon & Company

1450 BROADWAY, NEW YORK 18, N. Y.

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It's *NEW*...

GE Maxiservice Plan brings you finest x-ray apparatus with no investment!

One monthly service fee covers everything!

YOU BENEFIT

17 WAYS

WITH MAXISERVICE

MAXISERVICE is a specially designed service plan that for *one monthly fee* provides you with the specific x-ray apparatus to meet your particular x-ray requirements.

Best of all, you'll find the GE Maxiservice Plan provides far more than just fine equipment. It includes inspection, repair, installation, maintenance, instruction, tube and even replacement parts.

Investigate the GE Maxiservice Plan! It may be the answer to how you can equip your office with no cash investment. See your GE representative or write General Electric X-Ray Corporation, Dept. C-9, Milwaukee 14, Wisconsin.

GENERAL ELECTRIC

X-RAY CORPORATION

How many *really drop* on the floor?

Every salesman of cheap hypodermic syringes has one stock argument which runs like this — "Why pay more because they all break when you drop them on the floor?"

Floors were just as hard forty years ago as they are today and nurses were nurses even then. Yet, in the past forty years the life of hypodermic syringes in hospitals has been extended many, many hours.

The answer is, of course, that most syringes do not drop on the floor. In fact fifty per cent of the syringe breakage in hospitals occurs at or around the tip of the syringe. This fact can be demonstrated.

When making hypodermic purchases, you don't buy just a hypodermic syringe, you buy "hypodermic service".

Hypodermic Service is the true cost-in-use of hypodermic syringes and needles over a period of a month or a year. What you pay for HYPODERMIC SERVICE depends, not on the initial cost of syringes, but on how long a life of useful service those syringes give you. Longer service means dollars and cents saved.

B-D PRODUCTS
Made for the Profession

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Editorial

Does PR Pay Off?

• Any doctor digging down in his jeans to support the AMA National Education Campaign must occasionally wonder: Are public relations programs really worth the price?

If they're properly run and their cause is worthy, they are. But a PR program worth its salt must do two things:

1. Stimulate good works.
2. Create a better informed public.

In the good works line, medicine's present public relations counsel have consistently urged broader and better voluntary health insurance. They will urge it even more forcefully this fall.

And that's a good thing. For it gives people something constructive to support in opposition to compulsory sickness insurance.

Hark back a moment to a survey made in 1944 by the Michigan Health Council. This showed that when people were asked to choose between "the present medical system" and a Government medical system, 39 per cent picked the Government plan. But given a choice of other methods—including voluntary health insurance—only 16 per cent still voted for the Government scheme. PR had stimulated something worth-while and the people were willing to support it.

Now the idea of creating a better informed public: Why is this so vital? Because the more people know about a thing the better able they are to judge it.

In a survey made last year, the Psychological Corporation found that public opinion or any question reacts measurably to additional information on that question.

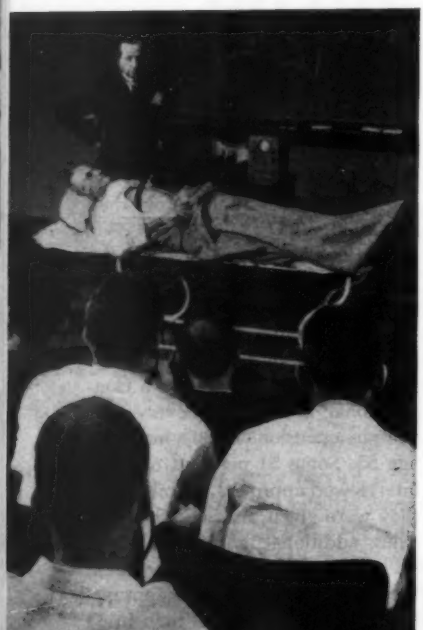
The test question was on a Congressional bill to give every war veteran a pension of $90 a month at age 65. Some 51 per cent of those interviewed approved the bill. Then they were given, in successive capsules, additional information about its cost and tax consequences. Steadily the percentage of approval fell, first to 43 per cent, then to 38 per cent, finally to 28 per cent.

Surveys on the compulsory health question have shown an identical pattern. The more people learn about the Truman-Ewing plan, the less they like it.

Do sound PR programs pay off? It has been proved repeatedly that they do. Medicine is simply proving it once more.

—H. SHERIDAN BAKETEL, M.D.

Every Hospital a Teaching Hospital!



● In the crowded conference room a medical educator was speaking.

"The brutal truth is, we just aren't keeping our active practitioners up to date. Some optimists have said, 'Wait until the doctors we are *now* training have been out ten years—then see the difference.' But today these men are further behind than physicians were fifty years ago—not because they aren't willing to keep up, but because science is throwing more at them every day."

The speaker was Dr. Robin Buerki, vice president of the University of Pennsylvania. It might just as easily have been any other medical educator. Or, for that matter, almost any doctor who practices outside the sphere of a large teaching center.

Small-town medical men are acutely aware that continued training—the *sine qua non* of modern practice—isn't easy to get. Yet if they *don't* get it, the forward march of medicine may leave them be-

How physicians in semi-rural towns can continue their education in big-city style

hind. How to keep up with the clinical parade?

Post-graduate courses are one answer. But only about 15 or 20 per cent of all doctors are believed to attend them. The rest find such courses too remote, too time-consuming, too impractical, or too costly.

A much more appealing answer is what might be called "on-the-job training"—the kind that staff physicians get in big teaching hospitals. Trouble is, this is largely restricted to the cities. Smaller hospitals in semi-rural towns don't usually have the diagnostic aids, the trained teachers, the contact with new developments needed to make the plan click.

Tailored for G.P.'s

But this picture can be changed. In semi-rural sections of Maine, Michigan, Massachusetts, and New York, it *is* being changed. Doctors in these areas—most of them G.P.'s—have come in contact with live-wire training programs based on a dramatic new idea:

Make every hospital a teaching hospital!

"A neat trick," you may say, "but not for *my* hospital. It has only about 150 beds. It has few diagnostic services, few trained teachers, no house staff, no contact with big-city medical centers. The place serves its purpose. But make a teaching hospital out of it? Not in a hundred years!"

In Western Massachusetts not long ago, many doctors were voicing these same sentiments. They practiced in peaceful towns like Greenfield, Northampton, and Holyoke—where the populations ranged from 15,000 to 50,000. Their workshops were places like the Franklin County Public Hospital (102 beds), the Cooley Dickinson Hospital (165 beds), and the Holyoke Hospital (140 beds). They got along with few pathologic checks on diagnosis, practically no autopsies, a bare minimum of lab work, no organized teaching program, little contact with clinical advances.

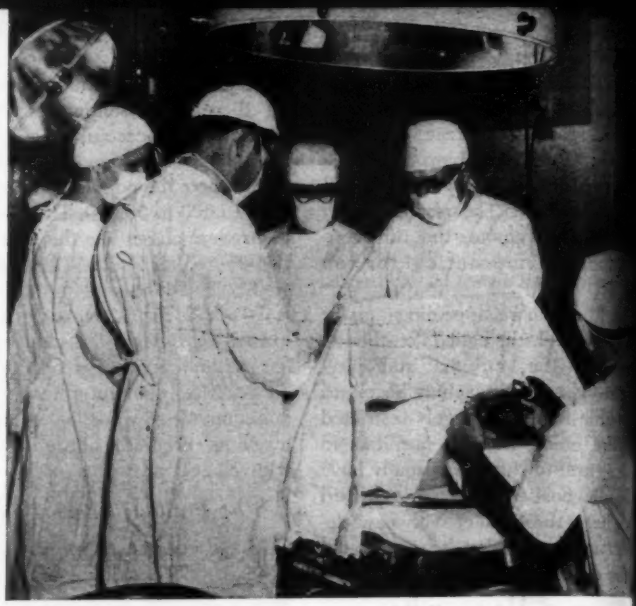
Why Patients Leave Town

"Some good medicine was practiced here," recalls a man who moved into the area shortly after World War II, "but in many ways our professional life was stagnant. Even patients noticed it. If they needed major work, many of them would bypass their local hospitals and head for Boston or New York."

Talking the matter over, local doctors gradually pinned down their problem:

The keystone of medical standards in any hospital is often a good pathologist. Local hospitals had no such keystone. Separately, they couldn't support one. But wait a minute: Could they swing it together?

The hospitals weren't sure. But they relayed the question to an experienced source in Boston. That source was the Bingham Associates Fund, which had helped set up re-



gional hospital programs in Maine. The Bingham people got interested.

Dr. Samuel H. Proger, for one, saw the Western Massachusetts region as a good place to invest in better medical care. Out of such an investment, he believed, would flow substantial benefits for patients, doctors, and hospitals. The main thing needed: a little pump-priming.

Here's how it was decided to prime the pump:

¶ A central pathological laboratory would be set up to serve all doctors in the area. A full-time pathologist would be found to run it. The Bingham Associates Fund and the Rockefeller Foundation would pay most of the bills until the lab was well established and proving its worth—at which point the local hospitals would take it over.

¶ Teaching residents would be assigned to the local hospitals. These men would supervise small house staffs to be recruited with Bingham aid. They would assist local doctors in getting maximum use out of their new laboratory. Working with the pathologist, they would organize on-the-job training programs designed to meet staff physicians' needs. The salaries of these teaching residents would be paid by the Bingham Fund.

On-the-job training at Cooley Dickinson Hospital, Northampton. Tissues removed by staff surgeons [◀] are picked up by circuit-riding pathologist for study in central lab. Cases are reviewed at staff meetings [▲] sparked by teaching resident (Dr. Herbert Perkins, left) and pathologist (Dr. J. S. Grewal, front row, left).

¶Local hospitals would get a new link with the New England Medical Center.* Thanks to this tie-up, the pathologist, the teaching residents, and interested local physicians would travel to Boston at regular intervals. There they'd be able to discuss their problem cases, their training programs, with nationally known specialists. The link would also offer support the other way: Top clinicians would regularly visit the outlying hospitals for talks or teaching rounds. All travel expenses would be paid by the Bingham Fund.

To many a Western Massachusetts doctor, all this spelled exciting news. Here, in one package, seemed to be the chief tools he needed for keeping up to date: the diagnostic aids, the trained teachers, the contact with latest developments. What's more, the tools were designed for use in his own workshop.

Other doctors—particularly the older ones—expressed doubts that the plan would work. One pathologist, they said, couldn't cover hospitals that were an hour's drive apart; he'd spend most of his time

*The New England Medical Center comprises the Tufts College Medical School, the New England Center Hospital (Joseph H. Pratt Diagnostic Hospital, Farnsworth Surgical Building, Ziskind Research Laboratories), the Boston Dispensary, and the Boston Floating Hospital.

on the road. And as for those teaching residents (in the words of one man): "I don't want any bright boys from Boston telling *me* what to do. After all, I've got twenty years' experience under my belt."

In March 1946, however, the scheme got under way. Dr. William Kaufmann, former associate professor of pathology at Albany Medical College, arrived in Northampton to set up a central laboratory. Cooley Dickinson Hospital provided the space. After $10,000 worth of modern equipment had been installed, Dr. Kaufmann made a quick tour of the cooperating hospitals to see what had to be done.

They were strung out in a forty-mile line through the heart of Western Massachusetts. The original three (Cooley Dickinson, Franklin County, Holyoke) were soon to be joined by Wesson Memorial, a 112-bed hospital in Springfield. All four, Dr. Kaufmann discovered, were practically devoid of laboratory services to back up the doctors' clinical diagnoses.

He buckled down to changing all that. To make it easy for local doctors, he instituted a personal pick-up service. Shuttling between the four hospitals at the rate of 2,500 miles a month, he collected all tissues and specimens removed in the operating room, brought them back to his central lab for processing and diagnosing. Reports were usually ready for the doctors within twenty-four hours.

As staff physicians got used to the luxury of prompt diagnostic studies, they called on Dr. Kaufmann for on-the-spot aid. In increasing numbers came requests for frozen-section exams, pathological work in the operating room. It got so that elective operations at the four hospitals had to be staggered, to ensure Dr. K's presence at the important ones.

Pathologist Rides Herd

"We soon learned," says Dr. Alfonso Palermo, chief of surgery at Wesson Memorial, "that the benefits worked two ways. The pathologist was kept on the ball by the volume and variety of specimens from four hospitals. Our staff physicians were kept on the ball by the pathologist. Needless to say, the final benefits were reaped by the patient."

You get some clue to the teaching value of this service from the autopsy rates. Before the Bingham plan took hold, the four hospitals averaged a scant three autopsies a month; Franklin County did none at all. Within a year, Dr. Kaufmann was doing about twenty-two autopsies a month. Which opened up a whole new avenue for the continued education of the medical staffs.

Here's where the teaching residents came in. Their assignment was to whet the interest of staff physicians in on-the-job training. Says Dr. Brooks Ryder, administrator of the Bingham plan: "You might call them the full-time di-

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The Law and Your Prescriptions

Some easy-to-read and easy-to-follow advice that can keep you out of trouble

• The patient was my lawyer and my friend. For the cough he'd consulted me about, I scrawled a quick prescription.

"You know," he said, "I'm always amazed at the casualness with which you medical men handle an instrument like this. You've signed your name to a document that calls for a drug—perhaps a very potent one. Once it leaves your office, it can never be recalled. Yet you seem anything but deliberate about it.

"We lawyers are used to handling documents that mean, at the most, money gained or lost. But we're a lot more careful than you are in writing out prescriptions that may mean *lives* saved or lost."

"Oh, come on, Harry!" I retorted. "You're just overdramatizing it. What could possibly go wrong? All this calls for is a harmless cough sedative."

Harry wasn't one to back down. So he tried another approach:

"Well, how about this line on the bottom? *Sig: As directed.* What does that mean?"

I explained that this told the pharmacist to attach a label reading: "Take as directed."

Harry pounced again: "That's just what I mean. Over the desk here, you just told me to take a teaspoonful every three hours. Suppose I'm kind of stupid and I think you said, 'Take three teaspoonfuls every hour.' With some drugs, taking nine times the dose might well be damaging. If I do that and then sue, what's your defense?"

"That the damage was caused by *your* negligence, not *mine*."

"It won't work," retorted the lawyer. "If you write, 'One teaspoonful every three hours,' then I have no case—at least none based on misunderstood instructions. But when you write, 'As directed,' it becomes my word against yours. And since, in the past, jurors themselves have been confused by medical instructions, they'll probably accept the patient's interpretation of what you said. In fact, your failure to write out the instructions may itself be construed as negligence.

"The 'As directed' label lays you wide open. Since you're signing your name, why not write out the instructions explicitly? Then you're protected."

"Suppose . . ." I countered, "sup-

pose in a moment of carelessness, I write a prescription calling for 15 milligrams of nitroglycerin instead of 1.5 milligrams. That will certainly be a damaging overdose and may be a fatal one. Still, the pharmacist knows, or should know, the normal dose range. If he knowingly issues medication calling for a fatal dose without checking with me, isn't *he* liable?"

"The physician would be equally liable. The patient could successfully sue either or both. Jurors would assume that the pharmacist had a right to assume that the doctor knew what he was doing. And they would almost certainly bring in a judgment against the physician.

Illegible Writing

"Of course, if you wrote the prescription properly and legibly and if the pharmacist made the error, then only he would be liable. I've noticed, though, that you have a rather illegible handwriting. If you write "10 grains" but, because of your hard-to-read script, the pharmacist reads it as 10 grams, I wouldn't blame him. Is there much difference between grains and grams?"

"There certainly is. A dose in grams is fifteen times as large as one in grains. But why should I be liable financially just because I have a poor handwriting? *Lots* of good doctors fail to write clearly."

"Perhaps so. But it's still careless to write a prescription illegibly. And in a doctor, carelessness is a good basis for a malpractice action . . . And while we're on the subject, let me ask you something else. Do you ever telephone your prescriptions?"

"Sure. Mrs. Jones calls me, says that her 9-year-old has a lot of wax in his ear again. I've been treating that child since he was born. If I ask her to bring him over and write out a prescription, she'll assume I'm trying to get another fee. All she wants is some more of the ear drops. I know her pharmacist, so I say: 'Mrs. Jones, stop over at Danley's Drug Store and they'll have the medicine for you.' Then I phone Danley and tell him what I want. I don't see anything wrong in that."

"The courts do. In the first place, she might misunderstand your instructions. Suppose she pushed that medication into the ear with a cotton pledget mounted on a toothpick. She could do damage, couldn't she?"

"She might rupture the ear drum. But it wouldn't happen. She's an intelligent woman. She'd never ream anything as rigid as a toothpick into the child's ear. Not a chance."

"That's what *you* think. But if she did, you couldn't squirm out of responsibility by saying that you told her to let the drops fall gently into the ear. She'd say that she didn't know how to apply the medication; and since it was a telephoned prescription, there'd be no written instruction to support you.

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BRIDGEMASTER

CLOSE UP

One evening last summer, three doctors at their first American College of Chest Physicians convention were looking for a fourth for bridge. Their prospects seemed bleak until the ACCP president-elect strolled by.

"How about a few hands of contract?" one of the doctors asked the ruddy faced man with the close-cropped white mustache and silver-rimmed glasses.

"Sure thing," said Louis Mark and sat down at the card table.

It was obvious from the start that, as a bridge-player, Dr. Mark knew his way around. He bid his hand with quiet assurance and, squinting through the smoke of his cigar, he played the cards with meticulous accuracy. When he won the rubber by making six spades on a squeeze, one of the younger doctors could no longer restrain himself. "Don't tell me everyone in Columbus, Ohio, plays like *that*," he said admiringly.

Dr. Mark admitted that his home-

Louis Mark checks tournament scores. Added up, they make him top M.D. in contract bridge.

town wasn't a land of bridge giants. "It's just that by limiting my practice to office appointments, I've found time for a bit of tournament bridge," he said.

Gradually, through questioning, the story came out: Louis Mark's spare-time bridge play had won him a place among the elite of the game. He was one of the 260 life masters of the American Contract Bridge League.

Hall of Fame

For tournament bridge players, the title of life master is the hallmark of success. Of the 30,110 players listed in ACBL records, less than 1 per cent hold this honor. It's an even greater achievement for a busy physician: Only two have made the grade; and Louis Mark is high man (No. 64 on the overall roster).

ACBL standings are based on performance in the 12,000-odd duplicate bridge tournaments held every year throughout the country. In most events, a player finishing in the top tenth of the field receives an award of "master points." When he accumulates 300 (at least thirty must be won in national play), he is ranked as a life master. Dr. Mark, with 609 master points, has more than twice the number necessary. And he's adding to his total all the time.

Although he has never won a world or national title, he has been racking up a steady string of victories in regional competition. A fine team player, he was a member of the champion team-of-four in the Minneapolis, Columbus, and Ohio Valley events last year. This March, he proved that he is a good partner for anyone by taking first place in the Obetz Individual Championship at Columbus.

Executive in Bridge

But 59-year-old Louis Mark is not content merely to play the game. He also takes a hand at running the nonprofit ACBL. As far back as 1930, he organized Ohio's first bridge unit. Last year he was ACBL president. He was awarded honorary membership in the league this year, a distinction bestowed on only one member annually for outstanding service to organized bridge.

Despite his exploits at the card table, Dr. Mark hasn't slighted his professional career. In addition to a thriving practice in the diagnosis and treatment of lung diseases, he owns and directs the Rocky Glen Sanatorium at McConnelsville, Ohio, said to be the largest private tuberculosis sanatorium in the United States. Every Tuesday for thirty-one years, except when away, he has driven 65 miles to make his rounds there.

TB, Too

Nor has his bridge-playing interfered with his winning recognition in his specialty. As president of the American College of Chest Physicians, which he helped form in

1935, he'll preside this year at its International Congress in Rome.

An admitted card-player, Dr. Mark realizes that some patients may think he is "wasting his time when he should be saving lives." But he has an answer: "I let my patients know that a doctor who follows a hobby clears his mind and is thus better able to diagnose and treat."

His own patients seem to accept this completely, for they have long taken his hobby in stride. Familiar with the trophies that decorate his office, they know when he's at a tournament, often ask how he's doing. So far, he's been doing very nicely, thank you. END

PILLDRIVER

CLOSE UP

He never set foot on a fairway until he was 32. Yet now, at 49, he's one of medicine's top amateur golfers.

That's the record of wiry, white-haired Clarence Ephraim Moore of Harrisburg, Pa.

In common with a number of his colleagues, Dr. Moore leads a double life. Mornings and afternoons he's a practicing surgeon. Evenings and weekends he can be found

Twice winner of the AMA golf championship, Clarence Moore uses an easy swing for a driving range of 250-275 yards.

pounding the course in pursuit of the little white pill.

Just two years after he took up golf, Clarence Moore began carrying off cups and ribbons. He won the Pennsylvania State Medical Association championship in 1935, then repeated his success in 1937. He won his own country club championship in 1937, 1938, 1939, 1942, 1948, and 1949. And he has won repeated championships at such "hot" golf spots as Hershey, Pa., and Hot Springs, Va.

His crowning and most gratifying achievement, though, was winning the American Medical Golfing Association championship—first in 1947 and again last year. His scores for the two events were identical: 148 for thirty-six holes. (His all-time record for eighteen holes is 68.)

Biggest dose of golf the doctor ever took in one day was fifty-four holes. His longest championship match was the Campbell Cup Tournament at Hot Springs, which he won on the thirty-eighth green.

Dr. Moore ascribes his success less to talent than to playing nine holes as many evenings as possible. "You'll always be a duffer if you play only on Sundays," he says.

The sweetest play he remembers was a 165-yard hole-in-one during a tournament. "No bounce, no roll," he says. "It dropped like a ripe peach into the cup."

And that experience, for Clarence Moore, could scarcely have been peachier. END

SOAPLANDER

Like twenty million U.S. housewives, Louis Berg of New York City listens regularly to that serialized form of radio melodrama known as soap opera. But unlike the housewives, he doesn't tune in for entertainment.

A portly, balding neuropsychiatrist and medico-legal expert, Dr. Berg, 49, has the distinction of being soap opera's most vociferous critic. He was the first to campaign against what he calls its "evil effects" on human emotions. Addiction to soap opera, he says, can result in everything from arrhythmia to vertigo, not to mention endless varieties of emotional instability.

Louis Berg and his wife live in a large apartment filled with French furniture and a romping, suds-white poodle named Danielle. He started his crusade into Soapland several years ago when he became convinced that daytime serials were contributing to the emotional malaise of his woman patients.

He had previously made a point of listening to fifteen episodes of each of the major programs. He says he found them bristling with pain-fear, rage, revulsion, frustration, insecurity, incest, and other

Dr. Berg tunes in his pet peeve—the soap opera—in his Manhattan apartment. He believes the despair of the 1930's still permeates such programs.

Freudian complications. "There appeared to be no happy characters in these serials," he says. "All were preoccupied with problems. They no sooner solved one than, without stopping to draw breath, they were involved in another."

Examples of dramatic situations he calls unhealthy are the story of a daughter who seduces her mother's lover; a hospital scene with a pneumonia-stricken child coughing and moaning in agony; a young boy who feels strong physical revulsion at the thought of seeing his father; a wife who decides she loves her husband only after he has had both legs amputated. "Pandering to per-

versity and playing out destructive conflicts," he says, "these serials furnish the same release for the emotionally distorted that is supplied by a lynching bee or the salacious scandals of a *crime passionelle.*"

The doctor doesn't believe *all* soap opera is harmful. He commends such programs as "Against the Storm" and "One Man's Family." But he is passionate in his denunciation of those that stimulate emotional tensions and reflect a distorted sense of values.

Too often, he says, "deceit, selfishness, and distrust" are presented as the mainsprings of human behavior. This theme, endlessly belabored, creates a morbid and hysterical excitement—the more so when it impinges on nerves already attuned to abnormality.

Louis Berg not only listens to radio plays, he has actually acted in several of them, although of a type somewhat different from soap opera. In the locally broadcast "Murder at Midnight" series, he played the voice of conscience in the De Maupassant story "Jealousy." Until recently he was also one of a regular panel of experts in the quiz show, "I Challenge You." "Other people play golf or fish for recreation," he says. "I act."

Many of the doctor's patients are theater people too. He particularly remembers an actor who played Oswald in Isben's "Ghosts," a drama concerned with the ultimate fate of a syphilitic. The man played it several years until it became apparent that his uncanny grasp of the role stemmed from the fact that he himself was verging on paresis. In response to Berg's urging, he dropped out of the play, submitted to treatment, and was ultimately cured.

In addition to turning out critiques of soap opera, the doctor has also found time to write three novels about his experiences as physician to the New York Department of Correction, a post he held for seven years. One of the novels, "Prison Nurse," was subsequently made into a movie.

Undoubtedly, this knack for dramatic writing and talking has stood him in good stead in his attack on soap opera. He is convinced that his zealous hammering via lecture platform and through newspaper and magazine articles has wrought improvements in the daytime serials.

Some of the networks, he points out, now employ psychologists and sociologists to doublecheck programs for harmful influences. He estimates that since his original attack, surveys amounting to half a million words have been made on the subject. But it's his opinion that the field could still do with more cheer, fewer tears.

So far, Louis Berg hasn't included television in his critical coverage. But only because it doesn't have soap opera yet. When it does, he'll be ready for it—with a ripe tomato in each hand. END

Where to Keep Your Spare Cash

Five handy places where your savings will be safe, yet will earn their keep

• Ralph Martin is that never-never bird, the typical American M.D. He's also our idea of a man who knows how to handle his personal finances.

Ralph has a three-line defense against financial trouble: (1) His checking account, which he keeps no larger than necessary to give him a respectable standing with his bank and to cover his routine home and office expenses. (2) His rainy-day funds, second line of defense—enough not only for emergencies but for the new car he'll be needing, for upcoming vacation expenses, etc. (3) His stock and bond investments.

What distinguishes the Martin financial scheme from some others is that rainy-day money. Most doctors keep some on tap, but too often it's simply part of their checking accounts. Ralph's draws interest—thus:

1. *Savings account.* He keeps about $1,000 in a savings account at the same commercial bank that carries his checking account. The interest rate is 1 per cent, about average among the country's 7,000 commercial banks. (More than 4,000 of them pay less than that, some pay as little as 0.5 per cent; 1,500 of them pay from 1 to 1½ per cent.)

Technically, Ralph has to give the bank thirty days' notice before he can withdraw any of his savings balance. In practice, though, the bank has always waived this requirement.

The interest rate is less than he can get elsewhere. But none of the other places is quite so convenient. Besides, the extra account at his commercial bank and the added contact it gives him with the bank's personnel, may come in handy if he wants a loan.

2. *Mutual savings account* Ralph is lucky in having a mutual savings bank in his town, since there are only 530 throughout the country, mostly in the Northeast. He has $2,000 on deposit and draws 2 per cent interest—again about average since savings bank rates vary from 1¾ to 2¾ per cent.

His withdrawal-notice period is sixty days (for some such institutions it's as little as thirty days, for others as high as ninety). But at present he can withdraw his money

without giving any notice at all.

Besides being a depositor, Ralph is a part owner of the bank—hence the word "mutual." The bank's trustees get no salaries. All earnings, after expenses and additions to surplus, go to depositors as interest dividends.

Mutual savings banks accept no checking accounts and make no loans. Many of them, like virtually all commercial banks, are members of the Federal Deposit Insurance Corporation, which insures deposits of $5,000 or less. Most mutual savings banks not insured by the FDIC are covered by state-operated insurance systems.

3. *Savings and loan shares.* Ralph has $1,000 in his local savings and loan society. Half of it is in a savings share account, to which his dividends are credited twice a year. The other half is represented by five $100 share certificates he bought several years ago. He gets a dividend check on these every six months.

His return, on both account and certificates, is 2¾ per cent. (Savings and loan rates generally range from 2 to 3 per cent; some of the smaller societies pay up to 4 per cent.) Technically, the doctor can be required to give thirty days' notice to cash in his shares or close out his account.

Savings and loan associations were originally organized to help people save for a home. Many are still known as building and loan associations. Massachusetts calls them cooperative banks, and in Louisiana they are homestead associations. Like mutual savings banks, they are mutually owned by their shareholding depositors. Assets are invested in home mortgages.

Though Ralph's savings and loan society is insured by the FDIC (out of 6,000 associations, 2,700 are thus covered), his investment here is somewhat less safe than the money he has in his two savings accounts. He is a creditor of the commercial bank, and a part-creditor, part-owner of the mutual savings bank. But his status with the savings and loan society is that of owner only, with no creditor's rights if the association fails.

If an FDIC-insured savings and loan society defaults, shareholders get their choice of accepting shares in another, solvent society, or of taking up to 10 per cent in cash, 45 per cent in a non-interest-bearing I.O.U. payable in one year, and the rest in another I.O.U. payable in three years. Some societies are old, sound, and profitable; others

are less conservative. Ralph looked into his society pretty thoroughly before investing in it.

4. *U.S. savings bonds.* The Martin program includes $3,000 face value of Series E Government bonds. He bought them at his bank for $2,250, or the standard purchase price of $750 per $1,000 bond. The bonds come in denominations as low as $25. No one is allowed to buy more than $10,000 worth a year.

The way these bonds pay interest is by growing in redemption value –from 75 cents per dollar of face value sixty days after purchase (you can't cash one before that) to 100 cents on the dollar at maturity date, ten years after purchase.

Ralph hopes to hold his bonds the full ten years. That way he'll get the highest interest rate: 2.9 per cent. (If he cashes them after only one year, his return will be 0.67 per cent; after two years, 1 per cent; 3½ years, 1½ per cent; 6½ years, 2 per cent; eight years, 2½ per cent.)

These bonds are the safest of all his rainy-day money deposits and investments. As obligations of the U.S. Government, they are bound to be honored unless the Government itself is overthrown. They are also the most liquid of his rainy-day resources. They can be turned into cash without notice any time after the first sixty days.

5. *Postal savings.* Until recently the doctor held certificates for $640 in postal savings. These he bought, $10 and $20 worth at a time, during his first two years in practice. They paid him 2 per cent, the standard rate throughout the country (except in Mississippi, where the rate is 1 per cent).

Postal savings certificates are for sale in even-dollar amounts. Interest starts on the first day of the month after purchase. (In most commercial and mutual savings banks interest doesn't begin to accrue on new savings deposits until the first day of the next quarter or the next half year.) Though postal savings offer the same safety factor as E bonds, and may be cashed at any time, Ralph recently converted his postal savings into an E bond (adding $110 to make the purchase

On the House

• Stomach trouble had been the bane of Mike's existence for quite a while. Finally his doctor, putting him to rights, rendered a bill. Mike stormed into the office and shook the bill under the physician's nose. "What's the meaning of this?" he demanded. "All along you said you were *treating* me." —LURAL LEE

price) for the sake of the higher ultimate yield.

In spreading his second-line defense funds among several kinds of depository, Ralph Martin weighed these factors: (a) safety, (b) liquidity, (c) rate of return, and (d) convenience. Each depository has one or more of these qualities to recommend it in particular; each has some measure of all four qualities:

¶ His commercial bank is his handiest place to deposit or withdraw savings; it is safe; and his savings account there benefits his relationship with the bank's personnel.

¶ The mutual savings bank, equally safe, pays him twice the interest rate he gets at the commercial bank.

¶ The savings and loan society pays him an even better rate of return, but it involves more risk; so his investment there is relatively small.

¶ The Series E bonds—which he considers partly rainy-day funds, partly an adjunct to his long-range stock and bond program—are safest of all, surest of quick convertibility into cash. But their generous interest rate is effective only if the bonds are held to maturity.

Taken as a whole, Ralph Martin's rainy-day money is as safe as it should be, pays as good a return as he can hope to get on such money, and leaves him able to put his hands on as much cash as he's ever likely to need in a hurry. END

Nation's Incomes Holding High

● About half the U.S. populace last year had incomes of $3,000 or more. The Federal Reserve Board puts it at 46 per cent of all consumer spending units (52 million families and individuals). In the $3,000-or-more bracket, therefore, there were half again as many units in 1949 as in 1945—meaning a 53 per cent jump in four years. The significance of this to doctors, medical societies, and prepay plans is self-evident.

Sharpest rise during the '45-'49 period was in the middle-income bracket, where the number of those at the $3,000-$7,499 level swelled from 27 per cent to 41 per cent. The under-$2,000 group, at 47 per cent in 1945, plummeted last year down to 33 per cent.

About 73 per cent of those surveyed most recently (Jan.-March 1950) said they expected their incomes to remain at the 1949 level or go up; 16 per cent feared a cut; the rest scratched their heads

More People Get More Money

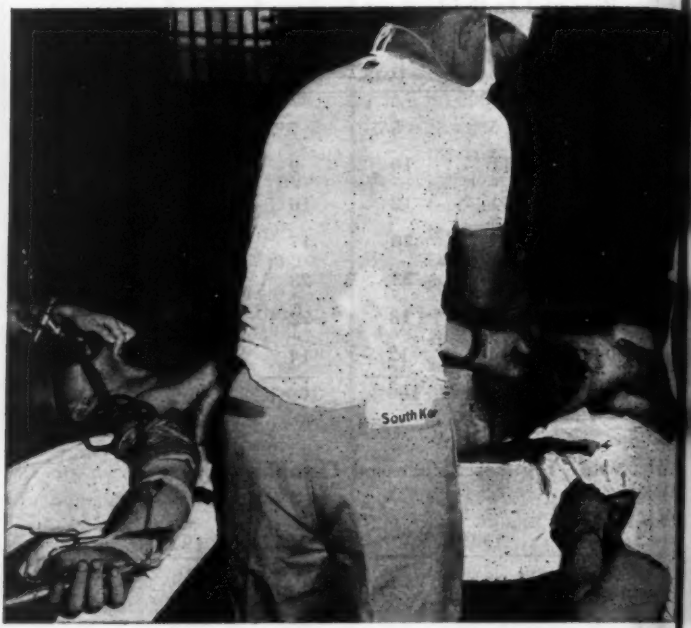
U.S. Families and Individuals at Various Income Levels

al Money Income Before Taxes	1949	1948	1947	1946	1945
,500 and over	5%	5%	5%	4%	3%
,000-$7,499	11	10	9	6	5
,000-$4,999	11	12	10	8	7
,000-$3,999	19	20	17	17	15
,000-$2,999	21	23	23	25	23
,000-$1,999	19	18	22	23	27
nder $1,000	14	12	14	17	20
All income groups	100%	100%	100%	100%	100%

Same Figures Expressed Cumulatively

al Money Income Before Taxes	1949	1948	1947	1946	1945
,500 and over	5%	5%	5%	4%	3%
,000 " "	16	15	14	10	8
,000 " "	27	27	24	18	15
,000 " "	46	47	41	35	30
,000 " "	67	70	64	60	53
,000 " "	86	88	86	83	80

ce: "1950 Survey of Consumer Finances," Federal Reserve Bulletin, June 1950. In- ata for each year are based on interviews during January, February, and early March following year.



Unidentified doctor operates on American soldier at rear-line hospital near Pusan, South Korea. Combat demands plus rapid expansion of troop strength at home have put physicians at top of military priority list.

Will *You* Be Called Into Service?

● "What are my chances of being summoned to active duty?"

In the minds of a good many U.S. physicians in recent weeks that has been Question No. 1. And with good cause. For the rapid expansion of our military strength has put medical officers high on the critically-needed list.

At the outbreak of the Korean fight, the medical manpower of the armed services was more than adequate. Military requirements called for some 5,300 medical officers. Actually, more than 6,000 were on hand—about 700 over and above the number needed.

But surplus soon turned to shortage as the military machine expanded. Appeals began going out to doctors—and to such other needed specialists as electronics experts, tank mechanics, and bombardiers—urging them to volunteer. The Army put in an early bid for more than 700 physicians, was expected to seek more. The Air Force wanted 800. Immediate Navy requirements called for 400 more M.D.'s.

How many physicians would be called up altogether? Pentagon authorities weren't predicting. But it didn't take much of a mathematician to come up with a rough estimate. Prior to the Korean crisis, the Department of Defense figured its medical requirements at 3.5 doctors for every 1,000 men. Using this as a measuring stick and supposing that by June 1951 the armed forces would be increased by 645,000 men as expected, more than 2,200 additional physicians would be in uniform at that time.

If anything, this estimate was conservative. Under battle conditions, a greater proportion of medical officers might well be needed. Not only that, but some military experts were predicting that considerably more than 645,000 men would be added to our fighting forces by the middle of 1951.

Where would the necessary med-

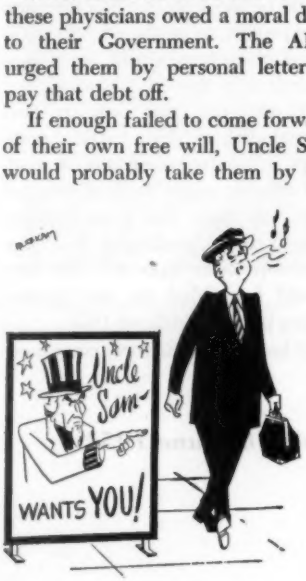
At least 2,000 more M.D.'s needed by June 1951

ical personnel be got? The Defense Department hoped that volunteers would make up a good share of the quota. But so far the response had been poor. The Army, for example, had sent out 3,000 letters to reserve medical officers asking them to return to the fold. Only 200 had replied, and a mere fifteen had agreed to go back into uniform.

More and more pressure for volunteers was expected to focus on the 7,500 or so former Army ASTP and Navy V-12 medical students who received all or part of their training at Government expense in World War II but saw no active duty.

Both the Department of Defense and the AMA let it be known that these physicians owed a moral debt to their Government. The AMA urged them by personal letter to pay that debt off.

If enough failed to come forward of their own free will, Uncle Sam would probably take them by the arm. One likelihood was an amendment to the Selective Service Act that would empower the U.S. to process any physicians who were not veterans. Said a high Pentagon official to a MEDICAL ECONOMICS reporter: "It's unfair to call back on active duty reserve officers who are veterans when we have a large number of men who received all or part of their medical education at Government expense and who are neither reserve officers nor have given service to the Government."



A number of lawmakers were beginning to share this feeling. Already in the Congressional hopper by mid-August were five bills designed to put the finger on the "morally obligated" group.

The AMA announced that it would support legislation, if necessary, to provide for the military call of physicians on a priority schedule, as follows:

1. Physicians who were educated during the last war and did not serve.

2. Physicians previously deferred for other than physical disability and those previously rejected for physical disability who are now fit.

3. Physicians who were educated during the last war and served less than twenty-one months.

4. Physicians who have seen less than ninety days of active duty.

5. Physicians who have had less than twenty-one months of active duty.

In case of prolonged mobiliza-

tion, the Council on Emergency Medical Service said, medical men should be rotated between military and civilian work.

Meanwhile, until some action was taken by Congress, shortages would be met largely from the pool of 30,000 medical reserve officers. Also on tap for immediate call were doctors who belonged to the National Guard. How many medical reservists had already been called was a Pentagon secret. Wraps had been put on such nation-wide totals to keep the enemy in the dark.

First to get their orders were physicians assigned to alert units of the reserves and the National Guard. Next were individual M.D.-reservists. The Army was summoning 734 of them to duty by October 1. The Navy and Air Force were expected to follow suit shortly. "Safest" group of reservists were internes and residents. They were assured that they would not get mandatory orders. (Internes and residents caught in the draft would also be deferred provided they took steps to get commissions in the medical reserve.)

If troubles abroad kept mounting, all reserves would, of course, be called up and the National Guard would be mobilized completely. Experts viewed the period from 1952 on as the time when the threat of world conflict would be greatest. So no letdown in mobilization was expected barring a peace agreement with Russia.

Hardly an incentive to physicians, but welcome news nonetheless, were the pay boosts that had taken effect since World War II. For example, a captain with dependents now gets $5,346 a year compared with about $4,000 in 1945; a major gets $6,381, an increase of about 30 per cent since 1945. Pay scale for other officers (with dependents): first lieutenants, $4,486.56; lieutenant colonels, $7,416; colonels, $8,784. Navy pay rates are the same for corresponding grades.

Actual cash received may be somewhat less. Included in the above figures are quarters and subsistence allowances (*e.g.*, $1,494 for a first lieutenant; $1,944 for a colonel) which are deducted when an officer lives on a military base. But real value is greater since the figures don't reflect such extra benefits as cheap insurance, bargain buying at post exchanges, retirement and disability pensions.

On top of this, of course, medical officers are entitled to an extra $100 a month—if they volunteer. Reservists ordered back to duty and M.D.'s scooped up by Selective Service don't get this.

For the medical officer who has already served a hitch, longevity pay may hike income by $100 to $300 a year. In unusual cases, it can amount to as much as $1,539. Hazardous duty also ups pay. Physicians get a special inducement bonus of $100 a month for such duty as flight, submarine, and parachute. END

Care and Feeding of Your Files

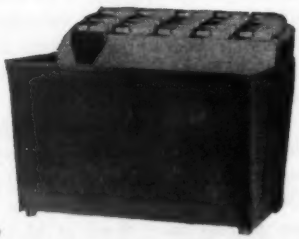
Rules and equipment to use for keeping papers always handy

● How fast can you get the paper you want from your files? Can your secretary pluck it out for you while you're on the phone? Or do you usually have to say you'll call back, after the elusive quarry has been tracked down?

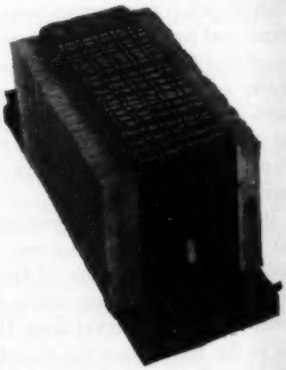
Instead of a divining rod, all you really need is a simple set of rules. With them, any intelligent girl can maintain your files so that they help you more than they hinder.

First thing she'll do is arrange all incoming material for prompt insertion in the proper folders. A sorter box (Fig. 1) with alphabetical separators helps speed this process along. It also provides a temporary file for papers not yet put away.

If she's smart, your secretary will put everything in its place before you've had a chance to make a mess of things. Then, when you ask for



1.



2.

Letter-size sorter box (1) holds material to be filed. When used for incoming mail, checks, etc., it keeps desks clear, cuts searching time. If sorting volume is heavy, an expandable device (2) may be more practical. It expands automatically as papers are inserted. The vertical separators and guides are interchangeable. Models range in width from 3″ up to 9″.

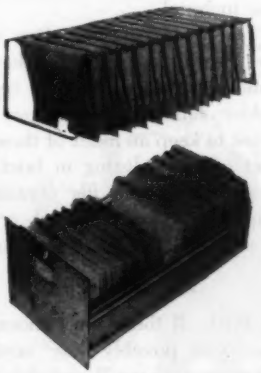
a record from the files, she'll note its withdrawal before giving it to you. Useful "charge-out" aids may consist of notations on a separate index file, or of letter-size cards to be inserted in place of material removed. These should describe the paper or folder taken out, name the person to whom it was given, and list the date on which it was borrowed.

At filing time, your Gal Friday may find it helpful to scan each item before putting it away. The impressions stored up in a few seconds are sometimes invaluable later on. While she's at it, she'll be removing most of the paper clips you used to attach items that are related to each other only hazily. Fewer papers will be lost if they're filed individually.

When two or more papers really belong together, staples hold them more permanently than clips. Some doctors, though, prefer not to use either, on the chance they may later want to microfilm their records.

Papers are easier to handle when they're of uniform size. Wherever possible, Miss Fixit will trim the oversize ones down to letter-size, taking time to mend tears with Scotch tape.

As for your file folders, they should stand erect without slump or sag. One device that keeps them in good shape is a series of cloth or fibrous pockets suspended from a steel frame (Fig. 3). The device fits inside your file drawer, holds your file folders neatly in its pockets, keeps them from getting old before their time. Variations of



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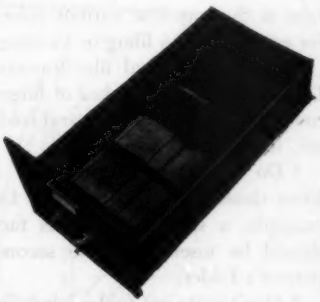


4.

Hanging file (3) keeps folders and papers erect in file drawer. Cloth pockets make folders more flexible for easy thumbing-through. Frames can be made to fit any size drawer. Metal plates (4) hold cards upright in small groups, tilt forward and backward, create wide "V" opening at desired point. Special attachment converts these plates for use in standard file drawers.

this principle are known as "Flexi-File," "Pendaflex," and "Redi-File."

Another handy device is the "Wobble Block" (Fig. 4) or "Adjust-A-Vider." This is a set of vertical plates that hold your file cards erect in small groups. When you reach into the file drawer for a specific record, the plates automatically tilt backward and forward, creating a wide "V" opening at the point of reference. The plates come permanently fastened to the file drawer, are also available separately for use with standard file cabinets.

Here are some practical do's and don'ts to keep in mind:

¶ *Don't* overload folders. About seventy-five papers per folder should be the top limit.

¶ *Do* insert a stiff, vertical separator every ten folders or so. These separators should carry identifying tabs at the top. Use various colors for extra speed in filing or locating.

¶ *Don't* overcrowd file drawers. Leave at least four inches of finger room to maneuver papers and folders, to allow for expansion.

¶ *Do* use cross-references. If a letter deals with two patients, for example, a sheet noting this fact should be inserted in the second patient's folder.

¶ *Don't* write out folder labels by hand. Typewritten ones are more easily read, more quickly prepared. Suitable blanks come in rolls or in padded, perforated strips, which are handy when you have many labels to be made up.

When to group items by subject rather than by name? Do this whenever the "what" is more important than the "who." Suppose you recall what some diagnostician had to say about detecting bronchial tumors, but not the man's name. Or suppose you have corresponded with several different colleagues on the subject. In either case, you'll be thankful if you can reach for a single folder marked "Tumors, Bronchial"—instead of leafing through your files for half a dozen folders labeled with half-forgotten names.

But it's worth keeping cross-references to each of the more important folders of this type. Then, if you happen to remember only one name or a related paper, you'll still find it easy to locate the bulk of the material.

One-word captions often suffice to identify a subject. They are quickly scanned, easy to type on folder tabs. Your secretary may want to keep an index of these subject captions, listing in brief summary what each file contains. A small, loose-leaf notebook or ordinary 3" x 5" cards are good for this.

Lost and Found

With all these precautions, how can you possibly lose anything? Don't worry—you'll probably find a way. Here's what to do while trying to locate a missing item:

1. As soon as the loss is discovered, jot down all you can remember about the item and note

the time you think it disappeared. Put this information on a letter-size sheet and file it in place of the original.

2. Begin your search among folders with headings similar in subject, spelling, or sound. "Knowlton," for example, may have been filed under "N." Poor handwriting may have caused "Barrett" to be confused with "Garnett." Over the phone, "Louis" may have been taken for "Lewis."

3. Examine any papers in the logical folder that are clipped together. The missing item could have hooked itself to another while being filed.

Gradually, your files will just grow. To keep them within manageable limits, your girl should do some periodic weeding of old material. Histories of discharged patients can usually be removed to storage files. Correspondence folders can stand clearing once a year. The best method is to remove letters in each folder beyond a given date.

Your subject file also has more value when pruned of dead material annually.

You and your secretary will no doubt think of other innovations that fit your particular needs. Keep them simple. For, as long as you stick to logical filing procedures, the basic rules to remember are:

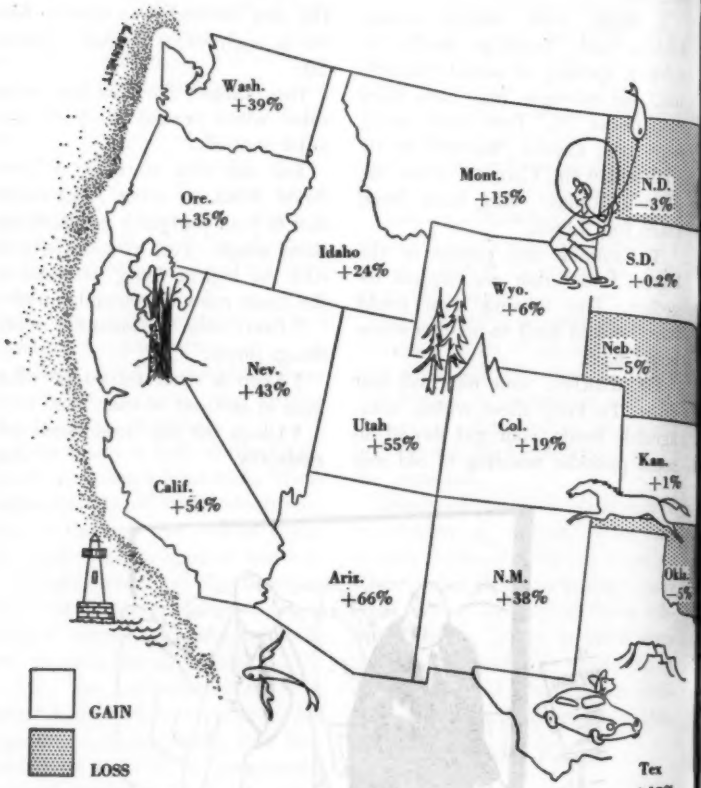
¶ Don't rely on memory; write things down.

¶ Keep a strict record of what goes in and out of your files.

¶ Clean out the dead wood periodically. END

". . . attended every convention for two years . . . up on every latest technique . . . then found my practice shot to hell."

U.S. Physicians: Where They're Going



Physician gain (all states): 17%

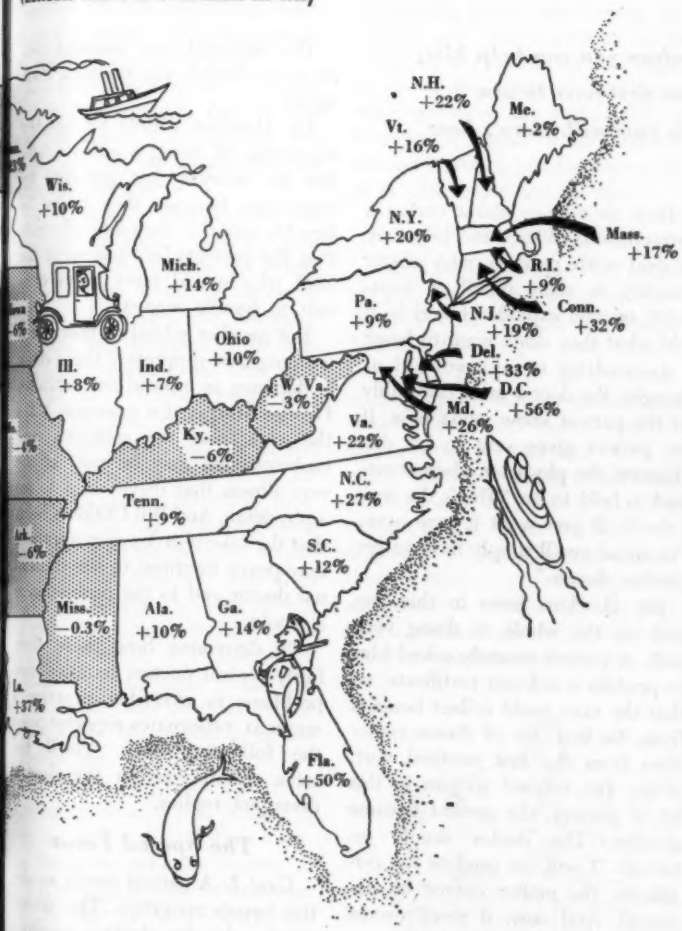
Population gain (all states): 15%

(July 1, 1937 to July 1, 1949)

Sources: American Medical Directory, 1950 edition; American Medical Association; Census Bureau.

Percentage of gain or loss in physician population during the last twelve years, by states

(Excludes M.D.'s in Government services)



Handling the Cantankerous Patient

Before you can help him, you first have to win his goodwill. Here's how

● How do you go about curing a curmudgeon? What's the best way to deal with patients who object irascibly to some detail of treatment, or who explode cholericly if told what they don't want to hear?

According to one school of thought, the doctor must invariably let the patient know who's boss. If the patient gives vent to his displeasure, the physician's best comeback is held to be, "That's the way *I* do it. If you want it *your* way, I'm afraid you'll simply have to get another doctor."

Jim Hawkins hews to this line and, on the whole, is doing very well. A patient recently asked him to predate a sickness certificate, so that the man could collect benefits from the first day of illness rather than from the first medical visit. When Jim refused to join in this bit of perjury, the patient became abusive. The doctor simply retorted: "I will not predate the certificate; the matter cannot be discussed. And now, if you'll excuse me, I'll see my next patient."

The offended one stormed out, never to darken the doctor's door again.

Dr. Hawkins admits he has the reputation of being a severe man. But he believes that patients respect him because they know he lays his cards on the table. He feels that the patients he's lost were the kind who would have been difficult to handle anyway.

But another school of thought is winning new supporters these days. It deplores an intransigent attitude. George Murray, for example, takes the view that the patient's cantankerousness may be part of the very illness that drives him to see a physician. And Bill Childers holds that the take-it-or-leave-it approach may prove injurious to the individual doctor and to the profession as a whole.

To determine how these three fairly typical doctors handled such problems in everyday practice, a MEDICAL ECONOMICS reporter posed the following cases. You'll find some useful cues in the doctors' divergent replies.

The Special Favor

Case 1: A patient needs an elective hernia operation. The doctor's regular day for elective surgery is

Tuesday. Monday would fit in better with the patient's sick-leave plans. He insists that the surgeon operate on Monday and becomes vocally vexed when told it must be Tuesday: "You're one of the chiefs at that hospital. You can operate on Monday if you want to."

Dr. Hawkins' answer: "I'd grab at that last remark, furnish him with the names of the Monday surgeons, and tell him to take his hernia to one of them.'

Dr. Murray's answer: "I'd let him blow off steam, then say that since he wants to enter the hospital on Monday, it will be arranged. He'll be admitted in the afternoon, examined and prepped in the evening, and operated on next day. Chances are, he'll never realize that this was the plan all along."

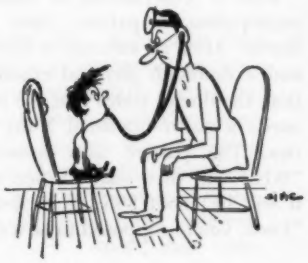
Dr. Childers' answer: "If he was serious and inflexible about it, I'd pick up the phone right in his presence. I'd call the operating-room supervisor, find out how the schedule stood for Monday, and—if it wasn't absolutely jam-packed—tell her that this operation *had* to be done on Monday. If I could get a Monday spot, all right. If not, the patient would have seen that I acted in good faith. That would be bound to soothe him."

Case 2: Having been injured in an automobile accident, a man is suing the driver. The latter's insurance company asks the patient to go to a certain doctor for examination. As part of the history, the doctor asks such questions as: How well did you sleep before you had the accident? Were you ever rejected for life insurance? This old scar on your head—what were the circumstances of *that* accident? Resenting this line of questioning, the patient says: "Look, Doctor, you're supposed to examine me. All right, go ahead and examine. These personal questions are none of your business. I expect to be cross-examined in court, but I'm not going to be cross-examined by you."

Throw Him Out

Dr. Hawkins' answer: "I'd throw my pen down with a bang and say: 'That will be enough, Mr. Smith. You can leave right now. There's the door.' Then I'd tell the insurance company that the patient was uncooperative and that I couldn't do a proper examination."

Dr. Murray's answer: "I'd wait patiently until he finished. Then I'd explain that a doctor can't make a diagnosis by examination alone—that a history is a necessary part of any medical study. I'd tell him why a physician has to have a well-rounded picture before he can



reach a conclusion. I'd say all this with a smile, and I wouldn't hurry him. If this tack didn't work, I'd change the procedure slightly and start getting the symptoms obviously related to the accident. He'd give these willingly. Then I'd relate each of these answers to questions about his health before and after. Even a cantankerous patient warms up under this roundabout treatment."

Dr. Childers' answer: "If he was that suspicious, he wouldn't give reliable data anyway. I'd see no point in pressing him further. Instead, I'd say pleasantly that I know just how he feels; if he'd rather not give me the information, I'd do the best I could without it. Chances are he'd feel a little sheepish and would cooperate thereafter. If he still retained his truculence, I'd proceed with the examination and report my objective findings. In my report, I'd simply state that I could not obtain a past history and therefore did not know how much of the findings to ascribe to the accident."

Price-Tag Problem

Case 3: Complaining of chronic constipation, a patient visits his doctor. After an exhaustive history and a thorough physical examination, the doctor states that the man needs a gastro-intestinal X-ray series. The patient asks uneasily: "What will that cost?" When told it will be about $85, he explodes: "Look, you're supposed to be a doctor, not a feeding station for X-ray men. Don't tell me you have to take pictures of my throat and stomach just to find out why my bowels move only twice a week. It's about time you doctors stopped trying to milk the public."

Dr. Hawkins' answer: "Sorry, Mr. Brown, but I know more about these things than you do. If you want a doctor just to give you a laxative, you can go to someone else. I don't practice medicine that way."

Dr. Murray's answer: "In your case, there's a chance that you may have something more serious than ordinary constipation. It wouldn't be fair to you if I merely told you to go home and take an enema. After all, you came here to find out whether you had anything seriously wrong. Well, the intestinal tract can't be examined directly because it's deep inside the body. Only an X-ray can give us the true picture."

Dr. Childers' answer: "I know that $85 sounds like a steep fee for investigating something as simple-sounding as constipation. If you feel you don't want to spend that much, let's at least do a barium enema. That will show us the lower part of the bowel—the part that's most often involved in the more serious diseases. If we can find the trouble there, all right. If you don't want even the barium enema, I'll try to treat you without that kind of help. But, for your own sake, I'd advise a more thorough check-up."

All of which suggests that the flat "No" is losing favor in doctor-patient relations. It's probably just as well. Public attitudes toward private medicine are increasingly affected by individual discourtesies. Besides, patients today seem easier to offend than they were a generation ago.

Why is this so? In the old days, laymen were carefully shielded from medical knowledge; everything the doctor did was mysterious and incomprehensible. The patient was in awe of him. Not so today.

The modern, medically-educated layman wants to know *why* a certain procedure is recommended. Gone are the days when "Doctor knows best" could silence the inquisitive patient.

Consider, too, the intrusion of so many third parties. Millions of patients today have some kind of medical care insurance. Benefits paid to a patient often depend on how a doctor words or dates his certificate—an obvious source of potential irritation.

Medical certificates, in fact, are now needed for all sorts of things —restoration of driver's license, waiver of insurance payment, employment or change of job, marriage licenses, and the like. Even getting on relief may require a medical affidavit that the claimant is physically unable to work. All these intrusions impair the reciprocal confidence that formerly existed between doctor and patient.

When the doctor could bring nothing but good, there was little reason for the patient to be cantankerous. Now the doctor's examination may lead to loss of a job, revocation of a license, or denial of a benefit.

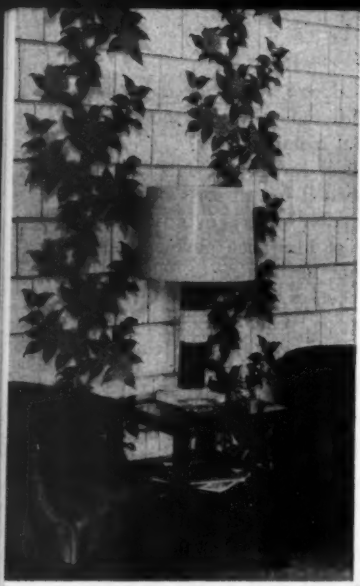
So minor frictions may be expected more and more often. The ideas presented here may help you lubricate the friction points.

—CHARLES MILLER, M.D.

Kibitzer

• The private entrance to my street-level office is one of its chief advantages, saving my more sensitive gynecological patients from encounters with doormen, elevator attendants, and so on. One such patient was telling me recently how much she appreciated this aspect of my location. She was on the examining table and I had just picked up my speculum. At that moment a small, piping voice outside the window added its own commentary: "Gosh, lookit what he's gonna use on her now, will ya!"

—M.D., NEW YORK



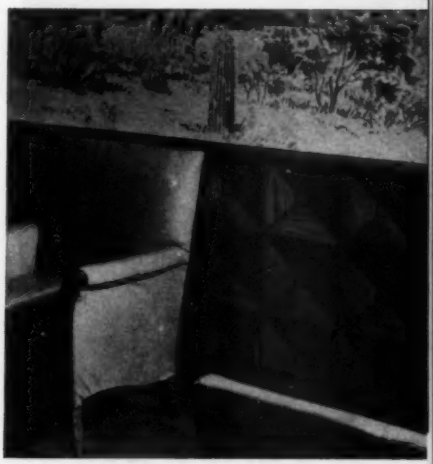
Here's American, country-style wallpaper with a pattern that will lend height to any low-ceilinged waiting room (furniture shown with it is too formal). For an entirely different, exotic touch, take a look at some of the oriental coverings hand-woven from hemp, grass, or metallic paper.

This wallpaper gives the effect of looking outdoors, thus "opens up" the large, walled area. Before buying paper as splashy as this, however, better let an interior decorator suggest what patterns to use and how.

Try Imagination on Your Walls!

• You don't *have* to stick to standard wall coverings. You *can* get individuality. All it calls for is an open mind and good taste. So next time you redecorate your office, shop around a bit. New materials appear constantly and the choice is a lot bigger than last time you had the job done.

The straw-like weave shown here is really a three-dimensional wallpaper coated with a washable plastic. It blends especially well with waiting-room furniture of rattan and reed.

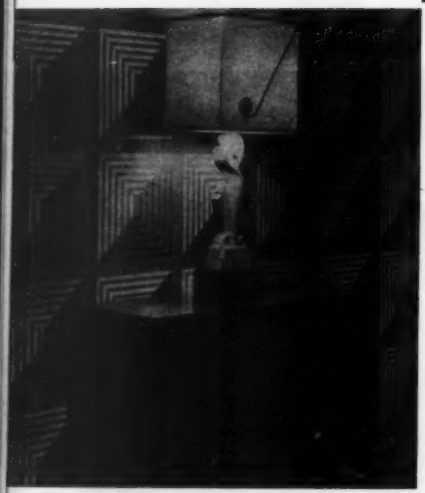


The three-dimensional paper covering this dado is a replica of real oak. Copper etchings impress the original wood image into the paper. A variety of grainings is available.

CONT. ON FOLLOWING PAGE

Try Imagination On Your Walls! (*Cont.*)

This seemingly woven wall covering is actually a plastic. It eliminates need for the finishing layer of plaster on a wall and can be painted any color. Other patterns can be had resembling bamboo and grained wood.



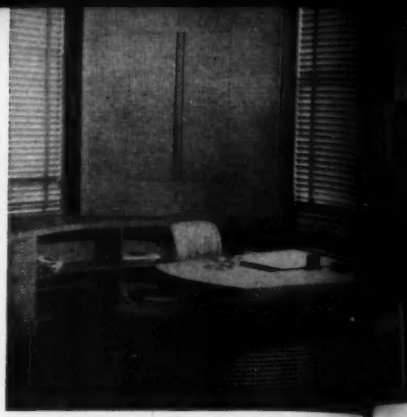
Here's a washable wallpaper with a metallic finish. The oblong design consists of powdered copper, gold, or silver said to be nontarnishable. The paper's synthetic plastic coating can be washed with soap and water.

Despite its natural-looking grain, the wall covering in this room is not wood, but fabric. Design is imprinted with washable lacquers. Fingerprints of small fry can be whisked off immediately with a damp cloth.

The covering on the wall of this waiting room is also fabric, minus the grain. Like the fabric shown above, it is crack-resistant and can easily be kept clean by washing. It goes well here with blond wood.

CONT. ON FOLLOWING PAGE

Try Imagination On Your Walls! *(Cont.)*



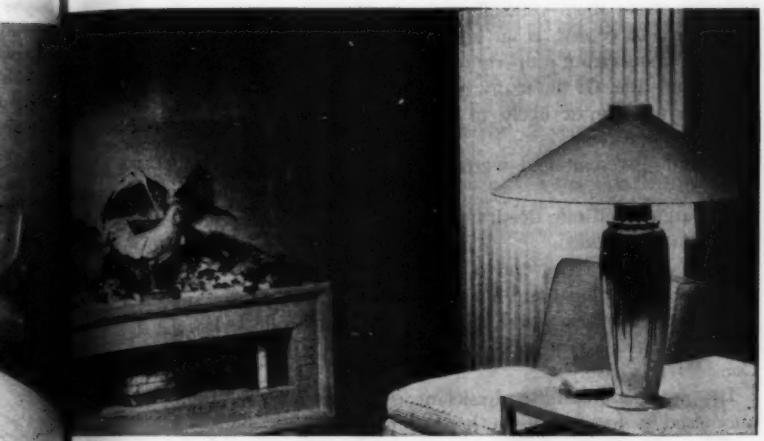
Plywood squares bonded to a flexible backing curve around corners. Cut in strips, they become molding.

Types of Wall Coverings

Wood
Cork
Metal
Fabric
Plastic
Porcelain
Wallpaper
Photomural
Simulated leather
Reconstituted stone

Walls and desk here are of laminated plastic, incorporating a layer of wood. Result is a natural-grained marproof surface. You can also get a simulated leather wall covering made of plastic, with a fiberglass backing, in a wide variety of colors.

These plywood squares are grained three-dimensionally to reflect light and shadows. Larger panels can be blended so as to create an effect of one continuous panel. Either a paint or clear finish can be used on them.



Cork is a natural insulator, helping to keep an office warm in winter, cool in summer. It's also sound-absorbent. Cork squares like those shown, when damaged or worn, can be replaced individually. A far cry from cork, yet also a good insulator, is stone. For an occasional interior wall, and for a fireplace too, this has possibilities. Available in powdered form, the stone is reconstituted on the job and applied to the wall surface with or without matrices in a choice of rough-hewn impressions and natural stone colors.

END

Have You the Right Kind of Deed?

Protection for your property ownership rights depends on it. Here are the facts

● Buying real estate? Then look out for booby traps—the paper kind commonly known as deeds. Even if you have a lawyer on the job, as you should, there's a lot you ought to know about them yourself.

A deed, of course, is an instrument for transferring property ownership and title. Of the many types in use, you're most likely to run across these three:

1. Full-covenant-and-warranty deed.
2. Bargain-and-sale deed.
3. Quitclaim deed.

Each can be a preventive prescription against legal and financial woes. But there's a world of difference from one type to the next. Consider this case:

Last year an eastern physician purchased a fourteen-room house on several suburban acres. Soon afterward, he came across a lease that apparently gave some mining company the right to quarry sand on his property. Alarmed, he sought legal guidance.

The doctor was lucky. Not only did his deed help him keep the mining company off his premises; it laid the cost of legal action at the door of the party who sold him the property.

He happened to have the strongest deed you can get: full covenant (promise) and warranty (guarantee). This is the kind that binds the seller to protect the buyer against any successful challenge to his title. If the physician had awakened one morning to find cranes and steam shovels rolling up his front lawn, along with a crew of pickax-packin' workmen, he could have sued the seller for damages—and collected.

Such a deed shields you from anyone who, at some future time, shows up with an unpaid mortgage, judgment, tax, dower, easement, or similar claim. Since the seller who

---

**Bernard Tomson, author of this article, is an attorney for many architects, engineers, and contractors. He writes a monthly column for Progressive Architecture magazine and is the author of a forthcoming book, "Law of Architecture, Engineering and Building."*

signs a covenant-and-warranty deed guarantees the title against such persons, these claims are automatically in his department. He has to satisfy all just claims or pay you for damages suffered.

But since it also obligates the seller to guarantee ownership to all future buyers of the property, you can't always get this type of deed. What then?

You may have to take the more commonly used bargain-and-sale deed. This signifies that the seller believes he has good title to the property but won't bet on it. He makes no guarantee of absolute title. Such a deed may contain some of the promises found in a warranty, but is usually limited to an assurance that the present seller has not done anything to make the title defective. Later, if you find you are *not* the absolute owner, you may have to bear the loss yourself.

If that's the best deed you can get, try to obtain a title insurance policy. This will protect you from any title defects that may later appear. The cost of such insurance depends on property value, location, and the like. Recently one New Jersey practitioner paid $241 for title insurance on property worth $30,000. In another state, he might have had to pay only about $200; in a third, closer to $400.

What about a quitclaim deed? It merely transfers whatever interest the seller may have in the property. It doesn't even imply that he's the owner. If he *does* have title, this deed transfers it; if not, you have no remedy against the seller.

A quitclaim comes into play only to eliminate certain doubts about ownership. If there seems to be a third party on the scene, see that the seller secures a quitclaim from him before you close the deal.

For each type of deed, the law prescribes standard forms and wording. In states where statutory forms are used, you merely fill in the blank spaces; in all states, lawyers can give you the required wording. Whatever the case, take special care to avoid the slightest ambiguity. Later on, if it's not perfectly clear whether the deed is a bargain-and-sale or a quitclaim, you may have to go to court—with resulting legal expense and possible adverse decision.

One thing that magnifies the importance of your deed is the difficulty of checking past ownership records. If your title is ever challenged, and if your deed doesn't fully protect you, you may have a tough job digging up the proof you

need. So put your attorney to work on a title search *before* you buy.

This may mean a prolonged check by your attorney back over a period of many years. To avoid random groping, some counties and states keep together all records involving any one property. Under this arrangement, (known as the Torrens System or Uniform Land Registration Act*) you can more easily find the original certificate of ownership, along with all evidence as to whether the property is absolutely owned by the prospective seller.

How should the deed be made out—in your name, in your wife's name, or both? Consult your attorney or accountant on this, since whatever you do will affect inheritance and property-income taxes.

When you're finally ready to sign, keep an eye on the formal requirements. Revenue stamps usually have to be affixed to the document; sometimes a seal is required; perhaps it is necessary to have a witness or two. Failure to comply with any of these essentials may nullify the entire deed.

Between the first interested glance at the property and the final signing of the deed, protect yourself this way:

¶ Consult your attorney before giving any deposit or signing any papers.

¶ Get a full-covenant-and-warranty deed, if possible. If you have to settle for a bargain-and-sale deed, take out title insurance.

¶ Make sure you get the deed you agree upon by having it checked for proper wording.

¶ Comply with all the necessary formalities in the recording act for proper execution of the deed.

¶ Record the deed immediately, so as to preclude any change in the agreement or in the status of the property.

Doing all these before you buy is much easier than bucking unexpected claims later on. Then, if there *are* any booby traps, you won't be the one who gets hurt.

—BERNARD TOMSON, LL.B.

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In a Word

• From the question-and-answer column of a British medical publication:

Q. Can you tell me the precise chemical formula, mode of preparation, and pharmaceutical properties of dihydroethylhexamethaline tetrachloride?

A. No.

—MEDICAL WORLD, LONDON

Group Practice – Is It for You?

If you've ever thought about switching from solo work, read this revealing report

• John Bailey is a general practitioner. Although he is still in his 30's, his practice is a large one. You might even say Dr. Bailey is badly overworked.

His daily stint runs to fourteen hours or longer. He has no free day during the week. Every Sunday he makes hospital rounds and up to a dozen house calls. Since his practice includes obstetrics, his sleep is often catch-as-catch-can.

John Bailey decided some time ago that he was just about fed up. His own physician had been warning him about overdoing things. He spent practically no time with his family. The career to which he was devoted now seemed almost a burden. Like many another doctor, he had a bear by the tail: He couldn't hang on and he couldn't let go.

Then, one day in another city, he ran into a medical-school classmate. Harry Doyle looked hale and hearty and full of ginger. It developed that he was a certified internist (Dr. Bailey felt an inner pang) and a partner in a successful medical group. In no time at all, John Bailey was inspecting the group's building, a handsome modern structure full of up-to-the-minute equipment. When Dr. Doyle asked him about his own career, he gave a frank account of his difficulties.

Harry Doyle, it turned out, was much better off. He worked fewer hours daily, had free Thursdays and Sundays, took an annual three-week vacation, attended at least one post-graduate course each year. And he was making considerably more money than Dr. Bailey.

"You're a pretty lucky guy, Harry," said John.

"Lucky? Well, maybe. But I'm not doing a thing that you couldn't be doing."

In the Pullman on his way home,

**This article is the first of a series describing the transition of a number of doctors from solo practice to group practice. Except for some disguising of names, this is a true-to-life case history. The author, George W. Condit, is a medical business manager in New York.*

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bibliography: (1) Donovan, M. A.: New York State J. Med. *45*:1756, 1945. (2) Reaser, P. B., and Burch, C. E.: Proc. Soc. Exper. Biol. & Med. *63*:543, 1946. (3) Griggs, D. E., and Johns, V. J.: California Med. *69*:133, 1948. (4) Chapman, D. W., and Schaffer, C. F.: Arch. Int. Med. *79*:449, 1947. (5) Modell, W.; Gold, H., and Clarke, D. A.: J. Pharmacol. & Exper. Therap. *84*:284, 1945. (6) Finkelstein, M. B., and Smyth, C. J.: J. Michigan M. Soc. *45*:1618, 1946. (7) Gold, H., and others: Am. J. Med. *3*:665, 1947.

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John Bailey pondered a long, long time—and then made a big decision. He would start a medical group in his home town. He hadn't the faintest notion of how he'd do it, or even how he'd get started. But his mind was made up.

In the weeks that followed, he sounded out a number of his colleagues. He found two—a pediatrician and an OALR man—who had been eying group practice speculatively. A third man—a urologist—had once been with a group and wanted to get back into that type of practice. Two others—an obstetrician and a surgeon—were interested but somewhat skeptical. All agreed to explore the subject in a series of meetings.

Dr. Bailey knew that the meetings would be nothing but bull sessions unless someone was present who knew group practice from the ground up. He phoned Dr. Doyle. Doyle knew a consultant—a layman—who had helped launch several successful groups. The consultant, Philip Radcliffe, agreed to come to the Bailey home and sit in at the first meeting.

On the appointed evening, the seven men got together in the big living room. After the host had distributed cigars and drinks, he turned the floor over to Radcliffe.

"I've had time for only a brief chat with Dr. Bailey," said Radcliffe, "but I have a general notion of what you have in mind. Perhaps the best way to start this discussion is to define exactly what we're aiming at. Then we'll all be thinking along the same lines.

"What you are considering, I suppose, is a group that will practice general medicine and a number of the specialties. You'll offer the public a wide range of diagnostic and therapeutic services. The group will be a sort of composite family doctor. It may get some referrals from outside physicians, but on the whole it will get its patients just as any private doctor does.

"You will pool your collections, pay operating expenses out of gross income, and periodically divide the net income. That division of profits will be made according to a formula you will have to work out. You will all be partners. Later, you may want to take in other partners or associates as you expand. Now, is this more or less what you have in mind?"

All the doctors agreed that it was.

Why Groups Fail

"At this point," continued Radcliffe, "you're uncommitted. For that reason, I'd like to make some pertinent comments. In my work, I've talked with physicians in many successful groups. Successful in two senses—they are practicing better medicine (or so they believe) and they are making more money than they made in solo practice.

"I have also talked with doctors who have tried group practice and abandoned it. Some were individualists who could not submerge

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their personalities in the necessary teamwork. Group practice is *not* for men who are overly aggressive or highly opinionated.

"Others could not get along with their colleagues; petty jealousies sprang up. Still others felt they could do better work in solo practice and so went back to it.

"Therefore, I'd like to give you both the pros and cons of group practice—the things that are said in its favor, the things that are said against it. Then you can start thinking constructively.

"So let's begin by reviewing the good points.

"First, there is the primary aim: better medicine. I personally believe—as do group physicians—that group practice offers the patient superior service. That's merely an opinion. I do *not* believe it will ever eliminate the solo practitioner. There will always be a place for him, especially in areas that cannot support a group.

"The advantage in the group is this: Multiple skills, diverse experience, and training can be immediately brought to bear on a case that might baffle the solo practitioner. Of course, the latter can always refer to specialists. But then he loses the patient, at least for the time being. The reverse is true in the group. The doctor remains in contact with his patient and he shares in the fees for special work."

"Isn't that fee splitting?" asked the surgeon.

"No," said Radcliffe. "Organized medicine has ruled it is not; state laws have been enacted to the same effect. And remember that most patients who come to a group see only a single doctor, for they are suffering from the minor ailments you run into every day. The doctor they see may be a general practitioner or he may be an internist; the important thing is, he's the family doctor. Back of him is the team of specialists, ready to enter a case at any time. This arrangement saves the patient a great deal of time and frequently saves him money.

"Medical teamwork becomes a daily routine. A single case history is prepared, with the specialists' findings correlated on it. There is no need for a man to grope about for a diagnosis when he's a little beyond his depth, or wonder whether he should send the patient to a specialist. The most modern diagnostic equipment is available. The benefits to the patient are obvious."

The surgeon interrupted: "I've heard it said that group patients are 'given the works'—put through diagnostic work-ups that aren't necessary—merely to produce more fees. What's your opinion about that?"

"That has happened," Radcliffe said. "But obviously only when doctors are greedy, dishonest, or incompetent. No need to discuss the first two types. The incompetent man may pass his patients through the clinic because he can't handle them himself. He has no

place in a group—or in medicine. A group that gouges its patients won't last very long."

John Bailey grinned. "I don't believe any of us wants to go into the hold-up business," he said dryly.

Income in Groups

"Well, we've considered the benefits to the patient," Radcliffe continued. "What about the doctor? Let's take income first. The last MEDICAL ECONOMICS survey showed that solo doctors had an average net income of $10,873, while group men netted an average of $16,493. Many group doctors I know have much higher incomes than that. In most instances, they earn it with less effort. I don't mean they give the patient less attention; possibly they give him even more. They just waste less time.

"For one thing, they are relieved of a vast burden of detail work. For another, patient traffic is organized better. One patient is being prepared for the doctor while he is treating another."

"Now you're talking my language," said John Bailey. "I'm particularly interested in knowing how a doctor can put in fewer hours of work, have days off each week and a vacation ever year, yet still give good treatment to a large volume of patients."

"Well," said Radcliffe, "there are the factors I just mentioned. The traffic is handled so that the doctor spends almost every moment *practicing medicine*. The general physician is relieved of the time-consuming obstetric and gynecological cases. He tends to become an internist and may in time, be certified as one. Night-call duty, in a fair-size group, can be rotated. In the same way, a group can close ranks and take over when a man goes on vacation or sick leave, or undertakes post-graduate work."

"Sounds good in theory," said the urologist.

"And that's exactly the way it works out in a successful group," said Radcliffe.

"The doctor," he continued, "spends no time talking about fees or past-due bills, or methods of paying them, with the patient. That's handled by the business manager. The doctor may set each individual fee or he may use a schedule—that is a detail we can discuss at some other time. But only the business manager is authorized to make financial arrangements with the patient. Of course that means more productive time for the physician.

"Such a system works well. A good business manager—one with a sympathetic approach—can work out a financial arrangement that suits each patient's ability to pay. Once it is made, he sees that the patient sticks to it. For that reason, a group can have a far better collection rate than the individual M.D.—sometimes as high as 95 per cent. The doctor forgets money and practices medicine.

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many other ways. For instance, the doctor uses a dictating machine to make comments on a case. They are transcribed and added to the patient's record by a medical secretary. The physician spends no time on record-keeping, and you know how onerous *that* can be."

"All this seems to call for a large number of assistants," said the pediatrician. "That means higher expense. In that connection, I've heard that the average group spends about the same portion of its income dollar on expenses as the solo man. Shouldn't there be a *lowering* of costs?"

"It's probably true that the expense ratio is about the same in both cases," said Radcliffe—"somewhere around 40 per cent of gross income. The point is, the groups get a great deal *more* for their 40 per cent. They have more assistants, and that means more productive time for the doctors and a greater gross income. Groups buy the most modern equipment. Money spent that way makes more money. The solo physician rarely gets the same return for his 40 per cent.

"There are other benefits for the doctor. Many groups now devote a good deal of time to research; he can become a part of it. Scientific meetings are held regularly. He gets more time to read his journals. If his group has a medical librarian, the literature in his field is abstracted for him. Forward-looking groups set up financial programs that assure security in old age. Few solo physicians enjoy all these advantages."

A murmur of assent ran through the room. "Now," said Radcliffe, "we've examined the bright part of the picture. Let's look at the darker side. Let's examine the defects that are commonly charged to group practice.

"First, consider the possibility that the patient will be overcharged through unnecessary services. We've already discussed that, but let me point out that even scrupulously honorable doctors may tend to overdo things in group practice. It's imperative, therefore, that the group's scientific committee periodically review diagnoses and the methods used to establish them. It will then be relatively easy to check any tendency toward unnecessary consultations or excessive use of diagnostic equipment.

"Another criticism of group practice is that it tends to lose the common touch. That could be a very real danger. A physician who works in an atmosphere of efficiency may

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become rather cold and detached. That could cost you more patients than an epidemic of the plague. Today, as always, the average person still wants you to ask him how John and Mary are, and when Joe is going to get out of college. Here group practice is no different from solo practice. But thoughtlessness might make it a great deal different, and that would do the group a lot of harm.

Professional Relations

"Then there is your relationship with organized medicine and with other doctors in the community. A decade or so ago, medical societies were inclined to look upon group practices with disfavor. It was thought then that the groups might establish a monopoly in medicine. That has not happened. Now most societies are friendly to groups and have even drawn up special ethical codes for their guidance.

"Unfortunately, private doctors are still somewhat hostile. The general practitioner feels that he may lose patients to a chromium-plated competitor. Therefore you specialists needn't expect any great number of referrals from outside. You can understand why. Even when you send the patient back to his doctor upon completion of your work—and you must be scrupulous about doing that—the patient himself may insist on coming to the group in the future. That's a knotty problem. I can't tell you how to solve it."

"It seems obvious, then," said the urologist, "that the work of the specialists will dwindle after they enter group practice. Won't their incomes dwindle too?"

"Yes," said Radcliffe. "For the first year or so, they would probably suffer a setback. But then a new factor develops—what you might call 'public referrals.' It is simply goodwill. One satisfied patient tells another. Then the specialist begins to get about all the work he can handle. It's been the experience of most successful groups that new doctors must be taken in within a few years."

"On the whole," said John Bailey, "I feel much encouraged by what we've heard tonight. How about you other men?"

"I agree with you," said the pediatrician. "The thing I'm doubtful about is the sudden switch from solo practice to group work. Not all of us may be able to afford even a temporary loss in income."

"Well," said Radcliffe, "there *is* another way. It's an alternate method that can be either a permanent arrangement or a bridge to group work. As it happens, I have just helped a number of physicians get set up this way, in a very loose form of group practice. If you want, I'll be glad to explain it to you in detail, and to describe the actual spadework of starting a group."

Everyone agreed. What the six doctors learned will be revealed in the next article of this series.

—GEORGE W. CONDIT

What's in the Wolverton Health Bill

It would provide Federal reinsurance of broader voluntary-plan coverage

• In a Reader's Digest article last spring, Republican Presidential aspirant Harold Stassen said, "Congress should create a Federal Health Reinsurance Corporation . . . [It] should provide that any local Blue Cross or similar plan [*e.g.*, Blue Shield] that meets certain minimum standard requirements can join by paying in 2 per cent of its annual premiums . . . The reinsurance would provide for refunding two-thirds of any amount in excess of $1,000 that the local Blue Cross was required to pay in any one case."

Now the Stassen proposal has been put before Congress in a bill (H.R. 8746) introduced by Rep. Charles A. Wolverton (R., N.J.). This would capitalize the reinsurance company by means of a $50 million Treasury advance. Income would take the form of receipts from member plans, plus a matching sum each year from Congress. To run the new agency, the President would appoint a three-man board of directors.

A prepay plan wishing to do business with the Federal Health Reinsurance Corporation would be required to:

¶ Fix a benefit period of not less than six months in any one year (compared, for example, with twenty-one days' hospitalization now provided by most Blue Cross plans).

¶ Scale its premium rate to the subscriber's income, up to $5,000.

¶ Accept non-group subscribers.

¶ Permit no cooperating hospital or doctor to charge a subscriber an additional fee of more than 25 per cent of the contract fee (except with Blue Cross or Blue Shield consent).

¶ Pay (in the case of a medical care plan) 95 per cent of a subscriber's medical care costs when at a hospital* plus 75 per cent of the cost of home or office visits (up to twelve visits a year, excluding the initial visit which would be paid for by the patient).

¶ Pay (in the case of a hospitalization plan) at least 75 per cent of the subscriber's hospital bill*, but make him pay the rest ($1 a day or 5 per cent of the bill, whichever were less).

The Stassen-Wolverton estimate

*Dental, nursing, and prescription costs excluded.

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of the cost of such coverage to the average family is $5 a month. Half this premium, in many cases, would be paid by the subscriber's employer.

Uncle Sam's Bill

But neither Stassen nor Wolverton venture an estimate of what the Federal Health Reinsurance Corporation would cost the Government. If all health plans came into the scheme, then boosted their membership to a theoretic maximum of 50 million families (at $5 per month per family), reinsurance premium payments to the FHRC would amount to only $60 million annually—the sum the law would have Congress match in appropriations.

This figure is so modest as to have raised the question: Could the FHRC actually meet all reinsurance claims against it without calling on Congress for a much bigger handout than the one stipulated in the bill?

This seems to be anyone's guess, even though Mr. Stassen says "no extra Federal appropriation would be needed because of safeguards [in the bill] against padding and malingering."

Meanwhile, the Wolverton measure has been referred to the House Committee on Interstate and Foreign Commerce, where it will probably grow whiskers. It raises to nine, incidentally, the number of like-type medical care bills now pending before (or pigeonholed by) Congress. END

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[1] Meyer, K. & Ragan, C.: Mod. Concepts of Card. Disp., 17:2 (1948)
[2] Quick, A. J.: J. Biol. Chem., 101:475 (1933)
[3] Guerra, J.: J. Pharm. Exp. Ther., 87:1943 (1946)

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Doctors Fight Hospital 'Extortion'

Rash of unethical demands breaks out in nation, with 'poverty' the excuse

• Are American hospitals using their poverty as an excuse to force private doctors into a state of servitude? There is evidence in some cases that this may be true.

Administrators and trustees are becoming increasingly committed to the theory that "All medical services of the future will be centered in hospitals." The AMA sternly rejects this notion. The American Hospital Association looks the other way. And the specialty societies cry bitterly, "It's later than you think," pointing to the already evident domination by hospitals of anesthesiologists, radiologists, and pathologists.

All this might be purely academic for the rest of the profession—were it not for the factor of public opinion. It's easy to spread this sort of propaganda: "Doctors make a lot of money in hospitals, but the hospitals operate at a loss. Why shouldn't the doctors help meet those losses?"

Nor is it very far to the next step: "Why shouldn't physicians become the partners of the hospitals?"

In various sections, hospital trustees and administrators have already taken the bit in their teeth. They have, in effect, told doctors: "We're moving in on your practices. Hereafter you'll have to split your fees with us. We'll collect from the patient for your services in the hospital and pay you your share. We're sorry we have to do this, but it's the only way we can keep the hospital open."

'Come Into My Parlor'

Other officials, more subtle, have "invited" doctors to make more use of the diagnostic departments—or else.

In each case where physicians have been forced to submit, they have violated the AMA Principles of Medical Ethics. These state categorically that "A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group, or individual, by whatever name called, or however organized, under terms and conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned."

Yet the tendency continues. A disturbing number of doctors *have*

been knuckling under to hospitals when threatened with loss of staff membership. It is happening all over the country. Here are some actual case histories:

Southeast: A small seaboard city was in trouble. Both its hospitals—in need of repairs and equipment—were on the verge of closing. Prominent citizens, under the leadership of physicians, got together. They formed a new corporation to run the hospitals more efficiently and economically. Staff physicians voluntarily agreed to pay the corporation a 10 per cent commission for collecting fees for medical services rendered in the hospitals. In turn, the corporation agreed to use its commission money to improve plant and equipment.

A year later the staff doctors learned that the money had *not* been used for improvements but for current expenses. They protested, threatening to withdraw the commission arrangement unless the corporation lived up to its agreement.

In reply, they got a stunning ultimatum: "Not only will this system continue, but hereafter the commission rate will be 20 per cent. And it will be compulsory for physicians who wish to remain staff members."

The dismayed physicians might have taken a number of courses. But they chose—in the interest of their patients—to submit. Thus, a vicious system, based upon compulsion and clearly violating medical ethics, was imposed upon the community.

But that was only the beginning. When the news got around, other hospitals went into action. One imposed "initiation" fees of $150 for general practitioners and $500 for specialists. Another forced its staff to agree to help underwrite operating deficits. A third really went to town: It told its doctors bluntly that it was muscling in for 50 per cent of their collections—not only in the hospital but outside it!

Before the thing got entirely out of hand the state medical association stepped in. It told its members to cease splitting fees with hospitals. It threatened the offending institutions that they would no longer be recognized by organized medicine if they continued such policies. That implied, of course, the loss of internes and residents. The association's prompt action ended—or is in process of ending—a nasty situation.

Midwest: A hospital in a large city was in desperate financial straits. Staff members tentatively agreed to make contributions to keep it going. Word of this promptly reached the local hospital council, composed of business men and hospital officials. A plan began to germinate. "If," said the council, "doctors are willing to pay to keep *one* hospital open, they'll pay to keep all of them open. Let's sell the various services as concessions to the highest bidders. Exclusive privileges to doctors should be worth plenty."

As a test, negotations were opened in one institution. Soon bids

of from $15,000 to $35,000 were being received. Then the county society stepped in and called a halt. There were some stern words behind closed doors and the "business-like" hospital council dropped the whole project.

Southwest: A city-county hospital told staff members they could no longer charge for their treatment of certain ward patients. The hospital now bills the patients for such medical care and appropriates all proceeds for its own use. Although the Judicial Council of the AMA has denounced this sort of arrangement as unethical, it was still in force when this was written.

New England: Certain departments of a hospital were operating at a loss. The chairman of the board of trustees wrote staff members, telling them that if the departments were more fully utilized the hospital would be in a better financial position. He therefore "urged" them to refer more patients for special (and presumably unnecessary) services. He was promptly rebuked by local medical organizations, whereupon he apologized publicly and excused his action by pointing to the hospital's empty coffers.

West Coast: Hospitals offer a "horse trade" to staff members. This is the deal: "If you want to use our beds, you'll have to direct your private ambulatory patients into our various departments for diagnosis, treatment, drugs, and other services." Such coercion has been condemned by the California Medical Association as restricting the free choice of physician.

These are typical examples of the growing encroachment of hospitals on private practice. Perhaps they are incidental skirmishes and not part of a broad, general strategy. Nevertheless, they are symptomatic of the widely held belief that eventually the hospital must become the master, the physician the servant. This view has been summed up by one of the ablest advocates of the new order, Dr. Dean A. Clark, director of the Massachusetts General Hospital. Says he: "The patient must be able to look to the hospital as the source of all the care he needs." —EDWARD E. BYAN

Etiology

• A door-to-door saleswoman was telling my wife about the virtues of a new underarm deodorant. Her chief selling point: The preparation did not stop perspiration, thus would not cause harmful wastes to back up into adjacent tissues and produce cancer of the breast. —M.D., IDAHO

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They Budget Patients' Health Costs

How one of the growing number of pay-on-installment plans is now winning friends for the profession

● His 14-year-old son had flunked math the day before. Maybe that's what Joe Sloan was thinking about when he forgot to slow down for the hairpin curve. Whatever it was, he put his car permanently out of commission, almost did the same for himself.

He wasn't too surprised, therefore, when he got medical and hospital bills totaling $237. But where could he lay his hands on that kind of cash? With a family of five to support, no money in the bank, and none coming in during his recovery, he was about ready to throw up his hands. Yet, one week later his physician and hospital bills were paid up.

Joe had no fairy godmother. He just happened to live in a city—Harrisburg, Pa.—where local practitioners have set up a plan to make medical bills easy to digest.

Here's how the plan worked in Joe's case:

His physician listened sympathetically to Joe's financial wo "Why not stop in tomorrow at o medical bureau," the practitio suggested. "They've helped a lot people straighten out medical hospital bills."

Joe decided to take his advic Next day he called at the headqua ters of the Medical Bureau of H risburg. An interviewer took him tow, explained how the bureau Budget-for-Health Plan works. S the interviewer:

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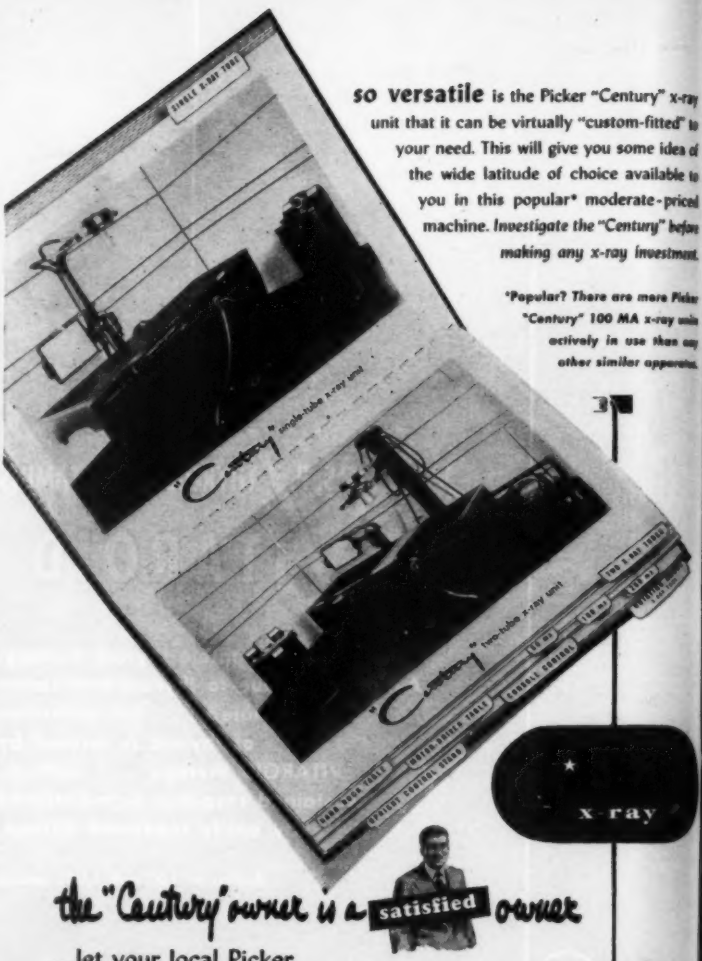
"Local doctors and dentists ha arranged through this bureau help patients like yourself finan their medical, surgical, dental, hospital bills—whether past, pr ent, or future. We pay your bills full after you've received profe sional services. You in turn repa us in convenient installments. The are no interest or finance charg Our members take care of opera ing expenses.

"Now, Mr. Sloan, what sort payments can you make each mo —and still be sure that you wo default on any?" Joe figured could afford $25 a month. signed a note for the amount owed.

During the next few days,



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reau investigators checked into Joe's credit rating, decided he was a good risk. His note was assigned to a local bank which credited the bureau's account with a loan in the same amount (at 4 per cent interest). Joe received a booklet containing ten coupons, one to be sent in with each monthly payment. His physician and hospital received checks totaling $218.04 ($237 less 8 per cent service charge).

Joe's experience is similar to that of many other low- to middle-income patient with no reserve for financial emergencies. In the last decade, budgeting plans have been cropping up throughout the country. In Pennsylvania alone, medical bureaus in Pittsburgh, Johnstown, and Lancaster operate schemes like the one at Harrisburg.

Full Payment Guaranteed

The primary aim of such plans is to help patients liquidate medical debts on easy terms, thus keeping bad accounts at a minimum. Some charge a nominal rate of interest for their loan service, others do it free. A few, like Harrisburg's Budget-for-Health Plan, go a step further: They assure member-physicians, hospitals, and dentists of full payment (minus a small service charge) upon completion of services.

As A. S. Cobb, manager of the Medical Bureau of Harrisburg and executive secretary of the Dauphin County (Pa.) Medical Society, says: "The plan eases the collection headache of the physician at the same time that it creates satisfied patients."

Some 3,000 such patients and their families have used Harrisburg's Budget-for-Health Plan since it was set up in 1942. The medical bureau has paid out a whopping $245,000 to about three-quarters of its 336 members* in payment for their services. Surgeons, hospitals, and dentists find the plan especially useful. G.P.'s use it mostly for obstetrical, fracture, and other cases that lend themselves to a set fee.

One measure of the plan's success is that patients use it over and over again. Take the case of Charles De Witt, a painter, who was unable to get health insurance for his diabetic wife. After she was hospitalized five times within three years, he found himself heavily in debt. At the hospital's suggestion, he contacted the medical bureau, paid off his obligation in installments. In the last two years, through the bureau's budgeting scheme, he has financed three more confinements totaling $767.

Even patients who have voluntary health insurance find the arrangement handy: An elderly widow was confined to the Harrisburg Hospital for sixteen weeks. Her Blue Cross and Blue Shield contracts covered only part of her bill. Her small pension was nowhere

*Membership includes 94 per cent of the county's active physicians, 85 per cent of its dentists, and its three major hospitals.

near enough to meet the $275 outstanding. Her daughter talked with bureau members, figured that she and her mother could afford to pay $20 a month. Hospital and surgical bills were settled immediately. The bureau was reimbursed on schedule.

Many patients hear of the plan through friends or relatives who have used it. Others find out about it through advertisements in the local newspaper. But the bureau doesn't believe in advertising it on a large scale. Says Manager Cobb: "We want our *members* to refer people to the bureau because that shows the physician's personal interest in the patient's welfare."

Member-physicians usually send their non-cash patients to the bureau prior to the completion of treatment. This assures prompt payment of the fee by the bureau and permits the patient to budget his income early so he can pay off the debt within a reasonable time. Obstetrical cases, for example, are referred to the bureau in the first stages of pregnancy. Often the patient has most of her note paid off by the time the baby is delivered.

Rate of payment is according to ability. "It's our desire to scale payments low enough so the patient is sure to meet each installment," says Manager Cobb. Terms are usually ten to twelve months.

The bureau will finance fees ranging from $50 to $300 (the maximum amount allowed by its bank). But what happens when a patient runs up bills over $300?

Suppose, for example, that Jim Collins wants to finance a $200 hospital bill and a $200 surgical bill

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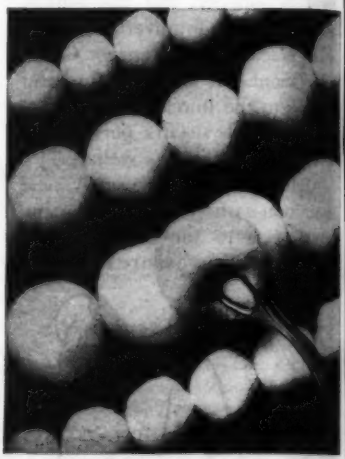

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through the plan. The bureau writes a note for $200, arranges for Jim to pay installments of $20 a month, sends off a check to the hospital. At the end of five months, Jim has repaid $100. The bureau then writes a new note for the remainder ($300), with terms of $25 a month, and a check is mailed to the surgeon.

What if a patient gets into financial trouble and fails to meet payments? The bureau usually extends the note until such time as payments can be resumed, absorbing the added bank charge to retain the goodwill of the patient.

If the patient refuses to pay, legal action can be taken. Actually, collection of loans has caused little loss. Only one account, totalling $136.50, has proved uncollectable. Since the patient was an ex-G.I. with a family of four children and a 75 per cent disability, the bureau absorbed the loss with no recourse to the courts.

"We find that the patient makes a special effort to pay promptly," explains Manager Cobb. "He knows his doctor is footing the charge for the service to ease the burden on him. Many patients react to this by paying in full long before they need to."

If the bureau feels from the beginning that a patient is a poor risk, it places him under its deferred payment plan. This differs from the regular procedure in that the bureau remits to its physician-member only as the patient pays on the note. The patient, however, is not aware of his special status. He assumes his bill has been taken care of. Thus the physician-patient relationship suffers no strain. If the application were rejected outright, the physician might be hard put to collect anything.

Not to be overlooked is the public relations value of such projects as Harrisburg's. Testimonials praising the plan and its backers are received daily. A letter received recently by the bureau illustrates the way many patients feel about their doctors' participation. A man had enclosed his last payment, then two months overdue. The delay, he explained, was due to a strike that had reduced him to part-time work. But despite his financial reverses, he wrote: "If my doctor's being charged extra because of my late payment, please let me know and I'll make it good." END

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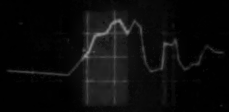

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1. Rosenblum, H. and Fraser, L. K.: Proc. Soc. Exper. Biol. and Med., 65: 178, 1947.
2. Dry, T. L., et al.: Proc. Staff Meetings Mayo Clin., 21: 497, 1946.
3. Bolisle, M.: Union Med. Can., 77: 393, 1948.

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Reply to the 'Loyal Opposition'

Doctors in general take issue with critics of AMA but grant some of their charges

• Has the success of the Whitaker-Baxter campaign lulled AMA leaders into the belief that no constructive moves are necessary?

That's the claim of the "loyal opposition"—some 200 distinguished clinicians and medical educators who have thrice protested the AMA's political-economic strategy. Their leaders include Drs. Edwards A. Park, George Baehr, Hugh J. Morgan, Walter Bauer, H. F. Helmholz, and W. Barry Wood. Three months ago in these pages, this group charged that:

¶ "Existing AMA programs fall far short of a plan that could be regarded as a reasonably adequate substitute for the Wagner-Murray-Dingell bill, opposition to which is our common objective."

¶ "The AMA is leaning too heavily on its education campaign. Its officers are looking ahead only as far as the Congressional elections next fall, and not beyond."

¶ "The AMA has yet to produce a carefully worked out, comprehensive plan to extend and improve medical care . . . which would be of clear advantage to the public."

Along with these barbs, spokesmen for the "loyal opposition" let fire a few constructive ideas: They urged AMA action to put across the recommendations of the National Health Assembly. They asked the AMA to put its own house in order, to pay more heed to minority views. And they declared: "Whatever program the AMA evolves ought to encourage medical service experiments *outside* hospitals—where the G.P. does most of his work and where there's a better chance for early detection."

The Majority Reports

There you have the views of one segment of the medical profession. What do other doctors think?

Take a look at the lively comment that follows. It stems from AMA officers, delegates, and trustees; from leaders in state, county, and specialty societies; from medical public relations men; and from rank-and-file AMA members. Here's how they react to what the "loyal opposition" wants:

From Dr. John K. Glen of Houston, Tex.: The protestors are, as usual, sitting on the sidelines and

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screaming at their former students like the fussy bunch of old maids they are.

They say they are 100 per cent against compulsory health insurance. Horsefeathers! Read their speeches.

They say they don't want socialized medicine. Oscar Ewing doesn't want it either—he says so himself!

They charge that the AMA hasn't produced a substitute for the Murray-Dingell bill. Of all the silly suggestions! The AMA doesn't want the M-D bill either as an original antique or in the form of a phony substitute.

They "lash out" at the AMA for its "unwillingness fully to acknowledge the need for improvement." Yet the fact is that improvement in medical care has come faster in America than anywhere else in the world. When the medical schools, for example, once had a mess they couldn't clean up, who recognized it and corrected the trouble? The AMA did.

Sure! All the AMA has to do to please the protestors is to socialize medicine—perhaps on a sort of quasi-government basis at first. But who can doubt seriously that it would degenerate in time into a full-blown government scheme?

One protestor really puts the cow on the roof with this statement: "The people want more and better medical care. Most people want it for *all* the people, whether all the people can pay for it or not. They and their representatives in government are determined to have it if it can be achieved by passing laws."

Well, it *can't* be achieved by passing laws—as repeated clinical trials have shown. If Americans are foolish enough to vote for something they can't pay for, should we of the AMA add to the antics by standing on our heads and uttering gibberish no more sensible than that of the protestors?

The protestors are, unfortunately, only limited "topflighters." As doctors of medicine, they are topflight; as students of freedom, they are consolation flight. History proves that Americans consider freedom more important than health. Yet tyranny is returning among us and our topflighters don't recognize it. They simply ask for more, saying that we are cowards to be afraid.

• • •

From a Missouri leader in Blue Shield: I agree with most of the criticism voiced by the "loyal opposition." It is bold. It is constructive. It is true.

Dynamic, spirited leadership will never be developed by the AMA as long as it perpetuates its present constitutional system. Under this system, the vast majority of policymakers are tired old men adept only at old-fashioned power politics.

Look at the Council on Medical Service—the body that should help solve the problem of better distribution of medical care: The AMA has persistently refused to place men on this council who are

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1. Knudson, S. C., and Cornell, E. L.: Am. J. Obstet. & Gynec. 56:853 (Nov.) 1948.

*Equivalent (by biological assay) to 1.5 mg. d, Alpha Tocopheral

experienced in the actual operation of medical service plans.

Everyone now agrees that these plans are a step in the right direction. Yet several members of the council vigorously opposed these plans earlier, and these members have never shown that they have changed their original thinking.

Put our own house in order and we will get leadership that *can* develop a policy acceptable to the public.

• • •

From a physician in Detroit: Most of the "loyal opposition" consists of salaried or otherwise subsidized practitioners, including teachers. Since no group of medicos is closer to the Federal feeding trough, one must be careful in accepting their point of view. Who, for instance, has screamed louder for Federal aid to education than the medical school deans?

In charging that AMA programs fall short of an adequate substitute for the Murray-Dingell bill, they overlook the fact that the M-D measure promises everything to everybody. On that score, no program could possibly beat it. Perhaps in being cautious about what it promises the AMA has shown commendable astuteness.

I agree that the AMA has been slow to acknowledge the need for improvement. It has, for instance, been lukewarm to the Blue Shield principle, which generally is working as effectively as the cupidity and the avarice of certain groups in the medical populace will permit. Maybe the AMA knows this and is made cautious thereby.

• • •

From an Arkansas delegate to the AMA: The "loyal opposition" says the AMA does not represent the rank and file. This is a groundless criticism. Policy-making posts have not, in recent years, been given just to "financially successful specialists." The family doctor is being recognized more and more in the high offices of the AMA.

Drs. Dwight H. Murray and F. J. L. Blasingame, for instance, of the Board of Trustees are both general practitioners from small towns. Dr. R. B. Robins, the new vice president, is a small-town G.P. Many other examples prove that the AMA leadership does not consist of men in ivory towers.

• • •

From a national figure in G.P. affairs: Too long has the AMA been dragged along like a stubborn bull pup at the end of a leash. Almost everything it has done in the field of socio-economics for the past twenty-years has been defensive in nature. I agree with the "loyal opposition" that some positive steps are long overdue.

Specifically, I am in accord with the chief complaint of the "loyal opposition": that no effective substitute for compulsory sickness insurance has been proposed. Adoption of either the Pennsylvania or the New Jersey proposal would answer this complaint. [*Turn page*]

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It chagrins and dismays me, for instance, to hear Frank Dickinson of the AMA contend that there is no shortage of doctors. I honestly believe that if we had twice as many practicing as we have today, the law of supply and demand would begin to manifest itself, and that complaints about overcharging, refusal to make night calls, and such would disappear.

* * *

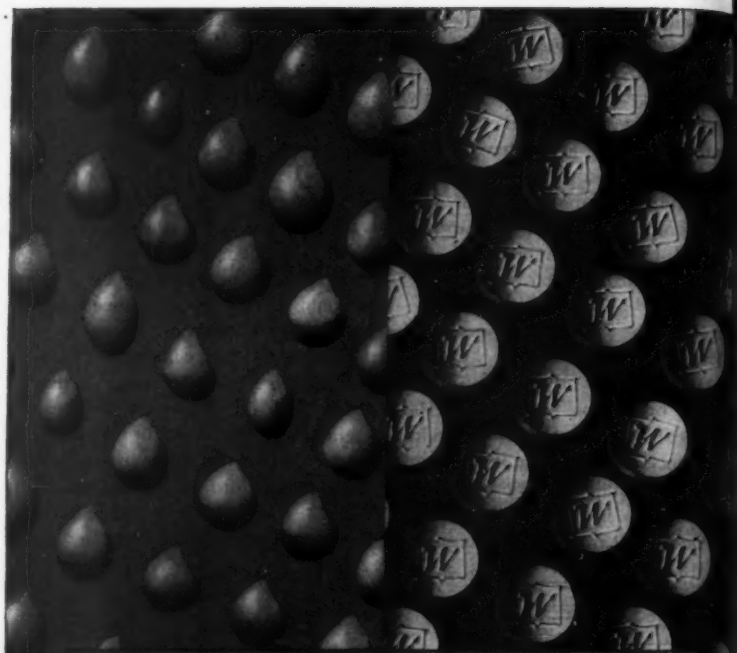
From Dr. Thomas O. Gamble of Albany, N.Y.: I disagree with the AMA officer who described the "loyal opposition" as being "100 per cent against compulsory health insurance." I am sure he is right about the majority, but not about all of them. Here's proof:

On April 15, 1946, Dr. Channing Frothingham of the Committee for the Nation's Health sent a letter to Senator James E. Murray. Enclosed was a statement signed by sixty-six doctors from many parts of the country, reading as follows:

"We believe from available experience that voluntary health insurance plans will be too expensive for the urgent needs of the American people. Therefore we favor a national health plan financed by compulsory insurance . . ."

Among the sixty-six doctors who signed this statement were Ernst Boas, John Peters—and thirteen members of the "loyal opposition"! You can look up their names in "Hearings Before the Committee on Education and Labor, United States Senate, Seventy-Ninth Session, on

"Can I substitute a Uneeda biscuit for the Melba toast?"



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• • •

From a medical society public relations director: One protest-signer is quoted as saying, "Our national association should stop hedging on health bills and decide what type of legislation it wants." But this diagnosis assumes something that isn't so: that legislation *is* needed. Just because we're opposed to legislation for compulsory health insurance does not mean we must support legislation for an alternative.

Politicians think in terms of political cures for all problems. Doctors would be wise not to fall into the same error. One of the greatest evils of our day is overdependence on government.

Then there's the suggestion that a "national, nonpartisan commission" be set up to make "a fresh study of this country's health needs." But as long as Mr. Truman is President, there's no way to assure that such a commission actually would be "nonpartisan." The Hoover Commission was set up under much more favorable conditions and even its recommendations are being twisted and distorted until Mr. Hoover himself is most unhappy. Anyway, the Brookings Institution is already engaged in a thorough study of health needs. The AMA is aiding in this study. So why start another under political auspices?

In recent years, the AMA has gained new importance both scientifically and in public affairs. It must, as a result, take steps to attract men of greater capacity. Some of its present personnel is top-rate; but any large association afflicted with seniority rights collects deadwood. The biggest job ahead of the AMA is to strengthen its leadership with men of constantly higher caliber.

Just as a democratic government lacks the decisiveness of a dictatorship, the AMA isn't always as quick to act as if one man dominated it. Morris Fishbein lost out because he sometimes made one-man decisions, expecting the doctors to follow along. Quite properly, the doctors resented this. The "loyal opposition" didn't like Fishbein; yet they sometimes expect Fishbein's celerity of action from AMA officers who are trying to feel the profession's pulse before they act.

The protestors charge the AMA with "unwillingness fully to acknowledge the need for improvement." There was some merit in this charge when it was made; there is less merit in it today. I think almost all are now agreed there is better feeling in medicine at present—and less nagging and petty criticism—than in many years. That in itself is a tribute to the current leadership, which even the "loyal opposition" should recognize.

• • •

From Dr. Arthur G. Blazey of Washington, Ind.: The "loyal opposition" member who said the AMA has learned nothing from the

experience of doctors in England, Australia, and New Zealand should have ample time on leisure hours from his 40-hour-a-week salaried position to read history. He should know that socialized medicine was adopted in those countries according to a blueprint for over-all socialism by a minority, and not because of any failure of the physicians to satisfy the needs of their people.

Socialized medicine in this nation would come about by the same means. If it does, our high standards of medical care will be relegated to the lower vales of incompetence and decay.

Members of the medical profession who claim to be against compulsory health insurance yet who still ask for a health set-up that could easily be captured by a Socialist regime should have no voice either in the AMA or in a government of free men founded upon the Constitution of the United States.

• • •

From a New Jersey medical leader: Personally, I am in sympathy with the views of the "loyal opposition." We in New Jersey agree that existing AMA programs "fall far short of a plan that could be regarded as a reasonably adequate substitute for the Wagner-Murray-Dingell bill." This conviction was the basis of our work in developing and promulgating the "New Jersey Plan."

Despite the easy assurance of AMA leaders that in three years we will have 90 million people under voluntary health insurance and that "when this number has been reached, the problem will have been largely resolved," we're skeptical. Unless some new gimmick is introduced, we believe with Dr. Paul Hawley that the growth curve of the Blue Shield plans will flatten out considerably below the 50 million mark, thus putting the medical profession in an extremely vulnerable position.

The idea of the "New Jersey Plan" was to provide a new gimmick in the form of a direct public subsidy to subscribers. For example, we proposed income tax deductions for individuals buying health insurance policies for themselves. We encouraged employers to underwrite part or all of the cost. We called upon the Federal Government to do the same for public employes. We urged local governments to buy voluntary insurance policies for their medically indigent.

If these things were put into effect, they would greatly increase the enrollment and coverage of such plans. Yet our proposals would not give any direct subsidy to the plans themselves. So there would be no possibility of governmental control.

We in New Jersey are as heartily suspicious of "big government" as anybody else. But we do feel it is high time for medicine to acknowledge that there are basic socio-medical problems before us and to show the people by tangible means that we mean to solve those problems

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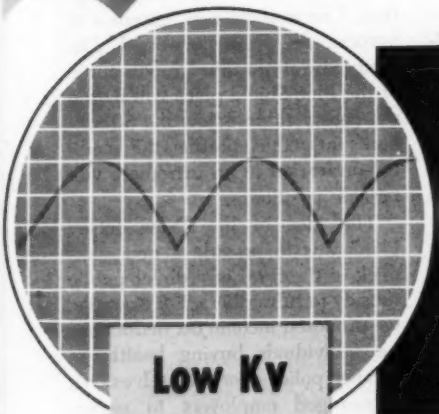

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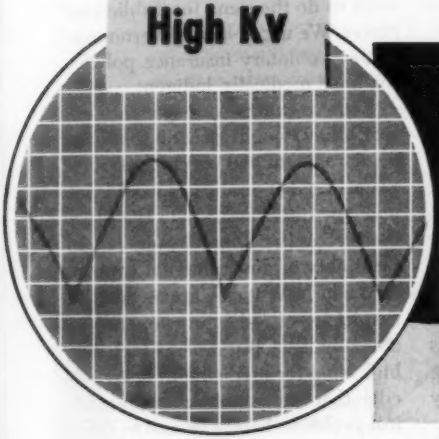

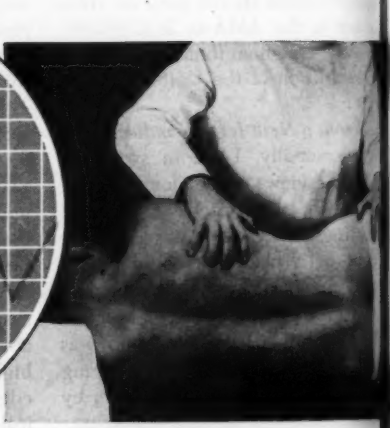

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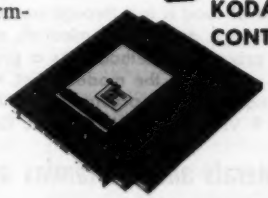

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and not merely to defeat candidates and beat bills.

• • •

From a doctor in Ohio: I agree that the AMA leadership has little regard for the opinions of the rank and file. But I strongly suspect that the "loyal opposition" is of the same stripe and has an equal disdain for the everyday doctor—the man who actually renders the medical service this country gets.

• • •

From a Texas M.D.: The "loyal opposition" is to be congratulated for its constructive criticism. Whether its ideas are right or wrong, its active interest in American medicine is a wholesome thing.

For too many years, we at the grass roots have confined our support of the AMA to mumbling and grumbling under our breath. Many of us have never been to its meetings.

We don't even send in our ideas unless we get burned up about some mistake it has made.

The present howling for a new and changed medical program did not come from the poor, or from the people in moderate circumstances, or from the well-off. It came from a minority in the bureaucracy that is Washington today. To combat their idealogy, I offer these suggestions:

1. Each physician must feel that he is a component part of the AMA, which is no stronger than its weakest member.

2. He must keep abreast of local, state, and national trends and pass along important observations to his professional organizations.

3. He must support his medical societies to the fullest extent, helping to elect the best men available to the important positions—and working just as hard to get rid of any individual who fails to discharge his duty properly.

4. He must remember that 95 per cent of American physicians are working to guarantee the people of this nation the best medical care at a price they can afford. The remaining 5 per cent are guilty of charging extravagant fees, demanding fees before service is rendered, worrying more about their pay than about the welfare of the patient, performing unnecessary operations and treatments. Every physician must see to it that his society deals with these violators fairly yet firmly.

5. We must realize that neither the AMA, the Congress, nor anyone else can evolve a medical care plan that will be either economical or practical for the entire country. Health programs and health insurance are more satisfactory and efficient when operated at the local level.

• • •

From an AMA trustee: I recently talked to one of the members of the "loyal opposition" en route from San Francisco. I asked him why he signed the protest. He said he was not satisfied with the AMA program. I then asked what construc-

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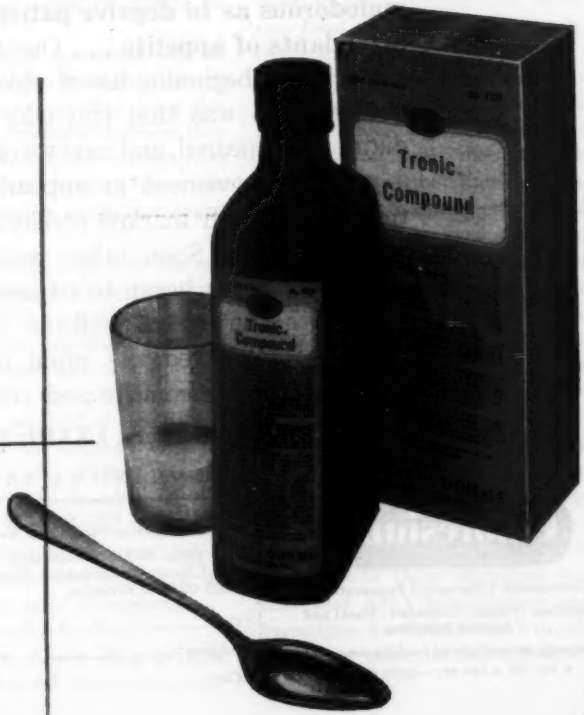

tive suggestions he could offer and –you guessed it–he had none.

What we need today, above all else, is a shoulder-to-shoulder front. Let the dissenters realize this. I have never been associated with a group of men whose minds are more open to logical, constructive suggestions than the officers of the AMA.

• • •

From a New Yorker: No one knows better what the common people need and desire, what local handicaps to health service there are, than the little family medic–who is never asked to express his opinion.

The big-shot specialists who issue communiques from the Chicago Citadel cannot possibly have this small-time viewpoint. Because they have been looking down their noses at the G.P. and treating him as an ignorant inferior, much resentment has arisen.

Let me, then, emphasize the referendum idea. I think the Inner Circle would be astonished by the results if, on important issues, it invited the opinions of the doctor in the street. The present closed-corporation method of doing business is not in keeping with the times. Since the Ewing proposal and the AMA counter-proposals both affect the rank-and-file doctor, let the victim have something to say–at least the few words granted the prisoner prior to execution.

• • •

From Dr. Elmer Hess of Erie, Pa., vice chairman of the AMA Council on Medical Service: I have been critical of the AMA in the past. Until I became a member of the Council on Medical Service and chairman of the AMA special committee for the study of physician-hospital relations, I did not know how easy it was to criticize and how difficult it is to accomplish things that are both legal and ethical.

It must be remembered that many of the "loyal opposition" are a select group–brilliant, full-time teachers–and that a large percentage of these men do not have to meet so-called competitive medicine head-on. They are also a relatively small group.

Many of these men are today reasonably sorry they touched off their 1949 firecracker. Their regret was made evident when some of them admitted that they had approved the statement in general and had signed their names without realizing all the implications. One of my dearest friends, a professor of medicine, offered to resign as president of his county society if his signature to the document had embarrassed the society. The society, of course, declined his offer.

The "loyal opposition" holds that "the AMA planning department has come to a dead stop." This statement is so far from the truth that I marvel that any man could make it. I suggest to these protestors that they visit AMA headquarters and investigate for themselves. I should like to see some of them appointed

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to our many committees so that they could know first-hand what is being done.

Concerning what happened in England, Australia, and New Zealand, I might say that the problem in the United States is hardly comparable. Even though leaders of the AFL and the CIO are for socialized medicine, the average working man in the United States does not want it.

I have been told on numerous occasions by people in the labor movement that they hope we do *not* get compulsory health insurance in this country, because they fear what it might do to their own movement. Do not think for one moment that the American working people are dumb. They are not.

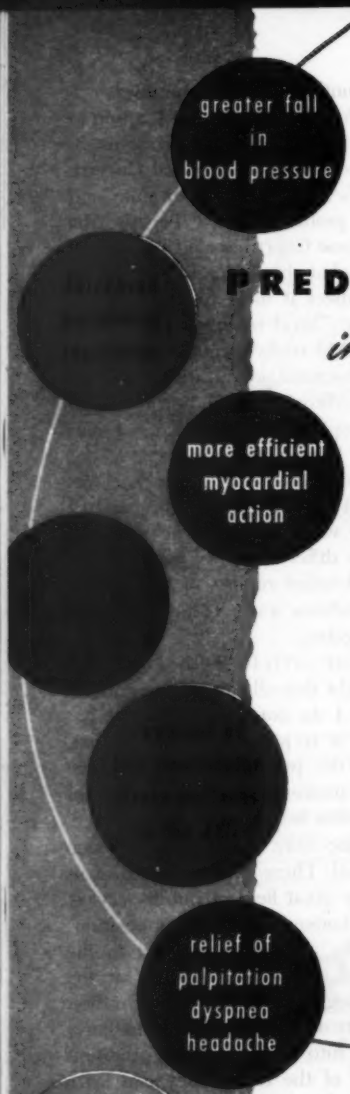
The "loyal opposition" wants the AMA to put across the recommendations of the National Health Assembly. These gentlemen should know that virtually every NHA recommendation has been advocated by the AMA. Legislation extending hospital facilities, local public health units, and Federally supported research has been endorsed. A Chronic Disease Commission has its headquarters at the AMA. A joint survey of medical education by the AMA, the Kellogg Foundation, and the Association of American Medical Colleges has been under way for over a year. The AMA's Committee on Rural Health has held several annual conferences whose recommendations constitute the positive program now in effect in countless rural communities.

When it comes to AMA action in the legislative field, many of us do not believe in the Federal Government's interference with state and local problems. Why? Because the Supreme Court has said specifically that what the Federal Government subsidizes it must regulate.

The "loyal opposition" says, "If the AMA really wants to prove it is a democratic organization, it should give editorial recognition to divergent opinions on controversial matters." I know of numerous occasions where, if one really reads the Journal AMA instead of throwing it aside when received, he will find many different views expressed in the detailed reports of the various committees and of the House of Delegates.

Your article finishes with the thought that all this is strong medicine. I do not believe it is. I believe it is just further proof that, until the present, few of us have been interested in the problems of the other fellow.

This entire controversy has been helpful. There is room for all of us in the great field of public service. It behooves the "loyal opposition" to take a more active part in the affairs of *all* medicine, to attend meetings and become active in their county medical societies, to carry back into their teaching programs some of the things they can learn from the men who are meeting every day the health needs of the American people. END



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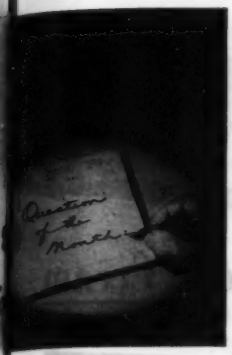


How Businesslike Should a Doctor Be?

One Man's Opinion

● To many a budding physician, anything that smacks of business seems a necessary evil in the practice of medicine. Yet it's hard to conceive of a successful doctor—successful in terms of the good he does—without considerable facility in this respect. Ask yourself, for example, whether even a small part of the Mayos' achievement would have been possible without it.

Many otherwise capable men limit themselves through business shortcomings. Take old Dr. Burd. When he died, everyone in his town mourned him as a benefactor of man. Of course, on that occasion, people preferred to dwell on his virtues rather than on his faults. In cleaning his office and rummaging through his ancient, roll-top desk, the family found eleven uncashed checks. Some of them were so old that the banks on which they were drawn had long since been liquidated. Digging deeper in that litter of yellowed receipts, bottle labels, and notices of medical meetings, they found an Oliver typewriter lost since about the time of World War I.

With better management, who can doubt that Dr. Burd's patients would have enjoyed more of the advantages conferred by medical science? For every misplaced check and unfiled paper, there may well have been a professional mistake resulting from his lack of system. Here also was the reason his widow had practically no legacy to fall back on, and had to turn for support to her sons. [*Turn page*]

The business mind has a quality much in common with the medical mind. It's often fair to conclude that a doctor who doesn't know how much Sam Smith owes him will not know what prescription relieved Sam's last attack. A doctor who doesn't keep books is likely to be one who doesn't read books.

A talent for business can be brought to bear on the doctor's problems of organization. First, he must organize his own activities to conserve time and energy. Unless he can boss himself, he can't get far in bossing others. Second, he must organize the activities of those who may work for him. In so doing, he has to keep in mind that a leader organizes to multiply himself. A physician who is a good organizer spends a maximum of his time in patient contacts. Other jobs he delegates, then supervises to see that they are done properly.

A talent for business helps in the recording of detail. A life "frittered away by detail" is, of course, a form of futility. Yet no physician can grandly dismiss details. A gynecologist who refused to keep a file of case histories because "I am a scientist, not a desk monkey" had a wrong conception of science. Think of all the records of all the guinea pigs that Roux and von Behring used in their work on diphtheria antitoxin!

Replacing a screw in your swivel chair is a minor detail the janitor can attend to. But keeping accurate, up-to-the-minute patient records is an important detail the doctor cannot completely delegate. [*Turn page*]

"Are you a Spock kid or a Gesell kid?"

What about money sense? It may be less important, but up to a point it's vital. Money is to be derided by neither doctor nor merchant, as Mr. Micawber implied when he told David Copperfield: "Annual income, twenty pounds; annual expenditure, nineteen ought six; result, happiness. Annual income, twenty pounds; annual expenditure, twenty ought six; result, misery."

Financial Check-Up

The only way a doctor can tell how he is doing financially is through a periodic check-up based on well-kept records. Cash receipts for the period, plus unpaid but collectible patient accounts, less expenses and accounts payable gives net earnings. A statement of total assets (including investments), from which total liabilities are deducted, gives net worth—a figure that has meaning only when compared with a similar statement for a previous period.

When net earnings are not satisfactory and net worth is declining, a detailed analysis is in order. Is the trouble in revenue or expenses? If it's revenue, are fees too high or too low? Or are you not collecting enough of your accounts? If it's expenses, what items? Is there an unprofitable part of your practice? If so, does it have to be that way?

One thing business has taught us all (and it doesn't take a tycoon to master it) is that the customer is always right. We can't heal everyone who comes to us, but we can treat all pleasantly, no matter whether they are pleasant to us or not. Our patients are sick people; they deserve tolerance.

Don't worry because you haven't a flair for figures or can't understand the futures market. But the answer to the question posed in this article should be clear: The business mind *must* be fused with the medical mind. There is an economic man as well as a physical, intellectual, and spiritual man. It was not without reason that John Locke linked together, in his great trinity of rights, these three: Life, Liberty, and Property.

—AS TOLD TO FRED DE ARMOND

Prognosis Deferred

● The doctor hadn't much use for the patient's wife, reputed to have married the old boy strictly for his money. But she hovered dutifully by the sickbed as the M.D. made his examination. Afterward, in the hall, she asked anxiously, "Is there any hope, Doctor?"

"That depends," he said, "on what you're hoping for."

Time to Expose the Economic Quack

He endangers our liberty no less than the medical quack endangers lives

● Theodore Roosevelt once said: "Every man should devote some part of his time to building the industry or profession of which he is a part."

Is this the counsel of idealism? Is it visionary to suggest that every man owes his profession some unselfish time, some time devoted strictly to the promotion of that profession—as distinguished from mere self-promotion?

Quite the contrary.

Few men lead more dedicated lives than the country doctors of our land. Yet, barring an event like the birth of quintuplets, how often is the service of the country doctor known outside the circle of his own grateful patients?

The same is true of the specialists in our cities. Miracles in medicine are expected of them and, when performed, are treated as routine.

There is danger in this situation—grave danger for the medical profession. Even worse, there is danger to the American way of life.

Today we say democracy—American democracy—is on trial. Too many are eager to testify for the prosecution; too few for the defense. Volumes are written about our mistakes, our failures, our weaknesses. But our strength, our achievements, our service are taken for granted.

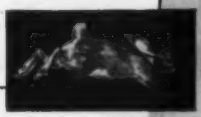
Tar Treatment

Those on the side of the prosecution—those who would paint America black—wield a mighty brush; make no mistake. They know how to magnify every flaw out of all proportion to its size. They know how to minimize every worthy thing we have done or are doing.

And they are succeeding to an extent we cannot view with complacency. For they are clever. They are united in their aims, disciplined in their methods. In short, they are organized. [*Turn page*]

**Baird H. Markham, the author, is director of the American Petroleum Industries Committee. This approximates his talk before the 1950 Conference of Presidents and Other Officers of State Medical Societies.*

why let healing drag on and on and on . . .



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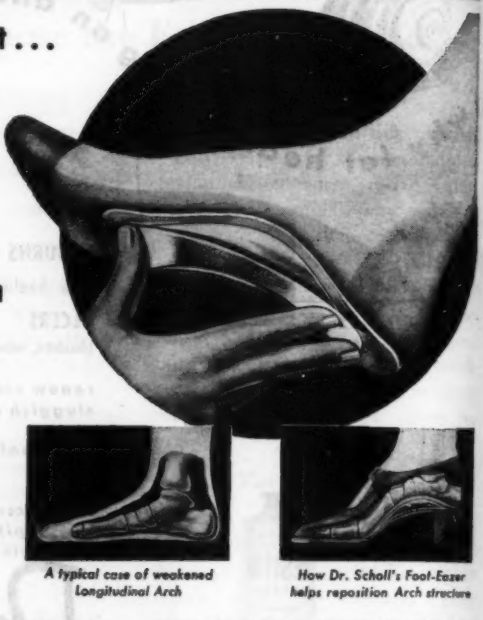

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These agitators insinuate that the individual must be regulated because he cannot be trusted. This is, in fact, the basic theory of those who would change our form of government.

Something Special

Now let's think about the opposite theory. Let's turn back to the time our country was founded. What is the feature of our Constitution that electrified the world, raised the spirits of the down-trodden everywhere, and caused tyrants to tremble? Simply the implied conviction that a citizen of our country is not a rascal. Neither is he a fool. He is, on the contrary, a man of essential goodness, capable of governing himself—and thus of playing a part in the government of his country.

In 1789 this was the most radical of all political concepts. But on the basis of developments since then, I submit it has proved workable.

We have blundered at times. We have stumbled and slipped. But we have always managed to keep our form of government in the midst of a world torn with revolution and littered with the ruins of fallen empires. Of late, we have even been able to contribute materially to the support of those governments that call our political procedure unsound and impractical.

The critics, the prosecutors, the detractors of the American way have no answer for this record of achievement. So they choose to ignore it—or, worse, to falsify it.

They picture the free enterprisers of the past—our American pioneers—as ruthless barbarians without principle, without mercy. Is this portrait a true one?

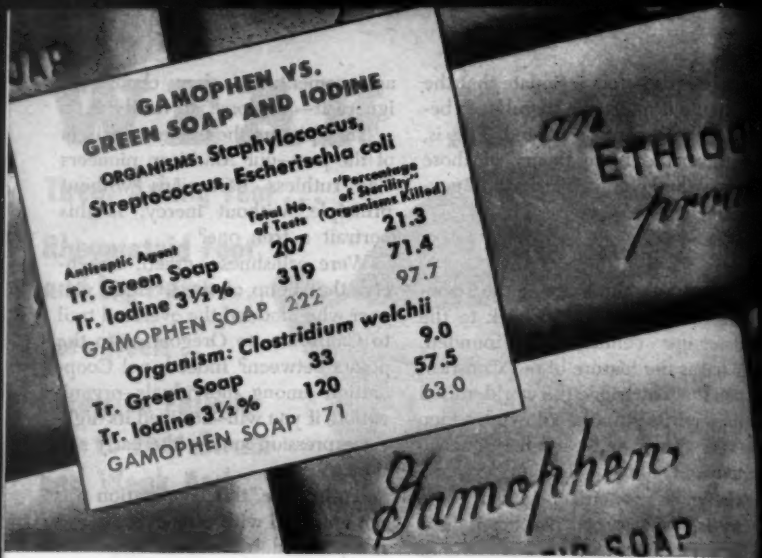
Were selfishness, greed, treachery, the stamp of the average pioneer who plodded the overland trail to California, to Oregon, or to the points between? Indeed, no! Cooperation among individuals—organization, if you will—attained its highest expression among the early settlers.

To be sure, this cooperation was not enforced with directives. It was not planned by a Washington bureau. It simply existed everywhere and was expected everywhere

The cooperation of the pioneers was the voluntary act of resourceful individualists, not the empty-minded obedience of cringing collectivists. For our pioneers were the kind of people who could follow the path of duty without the aid of road maps supplied by a paternalistic government.

In the strange new world these pioneers chose to invade, all the forces of nature were pitted against them. In the desert, in the mountains, on the trackless plains, death stared them in the face—death by starvation, by thirst, by flood and fire, by blizzard and cyclone.

Who could hope to go it alone in such an environment? Who could take an abstract view of the subject of organization or calmly debate



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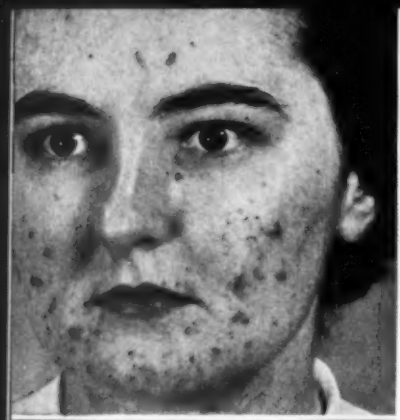

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the worth of cooperation with his neighbors? Then, it was organize or die, cooperate or perish.

It is still that way today, but in a different sense. For the death of our democatic way of life would mean the spiritual death of each of us.

Some critics say we cannot live now as our ancestors did because life today is so much more difficult. Voluntary cooperation won't work any more, they tell us; so we can't have security unless the Government gives it to us.

But what kind of security did the pioneers of America have? Who guaranteed *them* against the risks of famine and drought, of Indian raid and outlaw gang? What kind of security did *they* have except the security of mutual aid among neighbors?

Do the critics maintain that we are a different breed from the Americans of a century ago? And, if so, is it true?

The record of the recent war proves that the American people have *not* changed. They have the same courage, the same ideals—even though sometimes they have been misled in how best to attain them.

Our democracy can meet its present trial just as our pioneer ancestors met *their* trials—by the voluntary cooperation of free men.

What better vehicle is there for this voluntary cooperation than such existing trade and professional associations as, for example, the American Medical Association and the American Petroleum Institute?

Let's make no mistake about it: There is work to be done, and now. We need no ringing of an alarm to tell us that. Each of us is now in as great a predicament as the pioneer who saw the prairie fire raging around his cabin, or heard the war whoops of Indian marauders.

The crisis is not coming. The crisis is here.

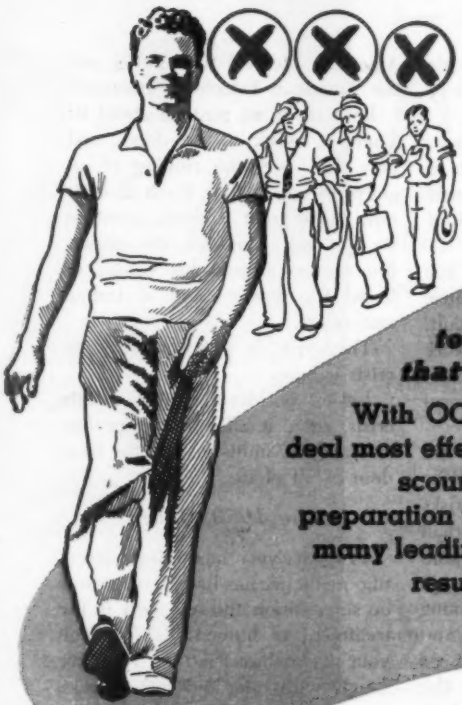
Let us consider the nature of this crisis, since it affects your profession and my industry, and the freedom of all of us.

The 1950 Quack

From its very beginnings, scientific medicine has had to wage war on superstition and quackery in the treatment of human ills. Through your medical associations, you have fought with valor and with success. You have exposed and checked the cancer quack, the glorified witch doctor, the peddler of fake cure-alls, and others who fatten on human suffering.

But today there is another quack abroad in the land—a quack no less dangerous. I mean the quack in the field of economics.

Those of us who take a common-sense view of political economy know that enterprise, investment, production, and employment cannot be encouraged by taxing industry down to its blood, bones, and marrow, or by regulating it to despair. We know, too, that govern-



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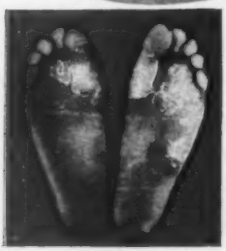
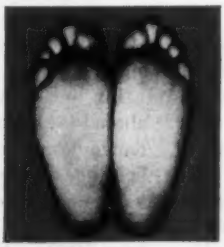


BEFORE
Athlete's foot 12 years' duration.



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*Med. Med. Topics, 10:7, July, 1949.

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ment has no independent source of wealth; that it can spend only what it takes from the people. We also know that deficit financing leads only to an illusion, like those fake hair-growing lotions that tint the fluff on a bald man's pate and give him the brief impression that he is cultivating a new crop.

We know these truths, but what good does just knowing them do? Of what use is a sound diagnosis if no attempt is made at treatment?

Jobs for Doctors

One of the most important tasks of American industry today is to spread economic truths to a public that is being drugged by economic fallacies. I would say that American industry must set about exposing economic frauds just as vigorously as your associations expose medical frauds.

In addition, both industry and the professions should make it a basic function to tell the story of their achievements to the public. Let us face the fact that the slanders now being hurled against business and the professions have for their purpose the destruction of the American way of life. The authors of these slanders plan to effect this overthrow not by violence, but by the slow poison of propaganda. Yes, propaganda against the oil industry, against the medical profession, against all private enterprise.

This propaganda must be answered vigorously, with the truth—with the record of what we have done, and are doing, for the American people. Remember that if the private enterprise system is overthrown, my business and your profession will be among the first to go because they are among the most solid props of the American system. Deprive *us* of freedom and *everyone's* freedom will soon be on the way out.

Get Into Politics

What more can we do now to meet the crisis? I hesitate to mention one except that it is so sadly neglected. This is the participation of all supporters of the private enterprise system in the affairs of their government on a local, state, and national basis. Not merely on issues affecting their own business or profession, but on all issues which, for better or worse, affect our future freedom.

This means, first, voting at all elections. Too many business and

"Please find check enclosed for your services in January 1942."

professional men neglect this elemental duty and privilege.

The next thing we must do—during, after, and between elections—is to support actively those who are working to strengthen and defend our system. Just as vigorously, too, we must oppose and defeat those who work against us.

There is only one way to save economic freedom in this country, and that is for each of us to be an active member of the rescue party.

Actions Speak Louder

Which brings me to another fundamental obligation: It is not enough merely to *tell* the people what we believe. We must *show* them what we believe—by our actions, by our attitude, by our display of faith and interest in the system under which we live.

If each of us will accept the challenge that the public reputation of his profession depends to a large extent on his own personal conduct in that profession, then the agitators and the critics of the American way will soon be left with no scandals to proclaim.

The average man judges the medical profession by the doctors he has known. He judges the oil industry by the oil men he has met. The importance of receiving a favorable judgment cannot be over emphasized. For we are both in an exposed position.

Industry, agriculture, and our military machine must have oil. The very economy of the country depends on it. Yet even more important is the need for medical care. *Our* work is concerned with material things—*yours*, with human life itself. So though our responsibility is great, your responsibility is the greatest of all.

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1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet. & Gynec. *57*:541, 1949
2. Chesley, R. F., and Annitto, J. E.: Bull. Margaret Hague Mat. Hosp. *1*:68, 1948
3. Dieckmann, W. J., et al.: Am. J. Obstet. & Gynec. *59*:442, 1950

sibility to be met? Let us reflect for a moment on what is being done to meet it now. What is the result of the present voluntary cooperation of the American medical profession and the American public? Anyone who reads the record of recent years will find inscribed therein an account of human progress unrivaled in the annals of civilization.

Show Them the Record

I'm thinking now of the growth of just one voluntary health plan—the Blue Cross—from fewer than 12,000 members in 1934 to more than 30 million today. I'm thinking of the employe medical programs now being provided by many corporations. I'm thinking of the private organizations that have been formed to fight cancer, heart disease, tuberculosis, polio, and many other ills that terrorize society. I'm thinking of the blood banks and the mass chest X-ray programs.

Only a Starter

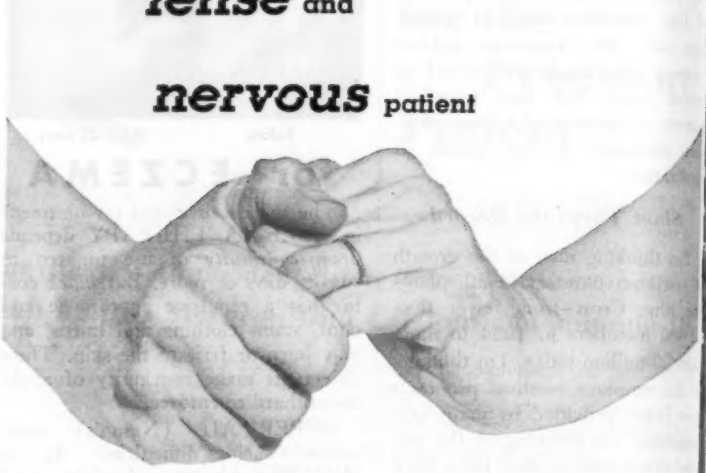
Of course, these are inadequate. Of course, they are only a beginning toward what needs to be done. But what a beginning! The time is now in sight when no barrier of region or of means will separate any American from the best of medical care.

It has been said that American democracy is on trial. Actually, it is *we* who are on trial. If we fulfill the responsibility placed on us, I don't see how democracy can fail. For, after all, *we* are the parts that

for the

tense and

nervous patient



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make up a democracy. And if the parts are sound and true, the whole must endure.

In the Second Century, a young pagan of the Roman Empire, noting the strangely different attitude among members of the rising Christian sect, said, "See how these Christians love one another." Soon he, too, was converted to Christianity—not by sermons and tracts, but by example. He did not have to be lectured on what the Christians believed. He saw for himself what they believed by the way they conducted themselves.

Some day, I hope, an observer in this country will exclaim with equal admiration, "See how these Americans love their democracy"—judging us by our actions, not by our claims.

When that day comes, we will have proven our case and the future of American democracy will be assured. —BAIRD H. MARKHAM

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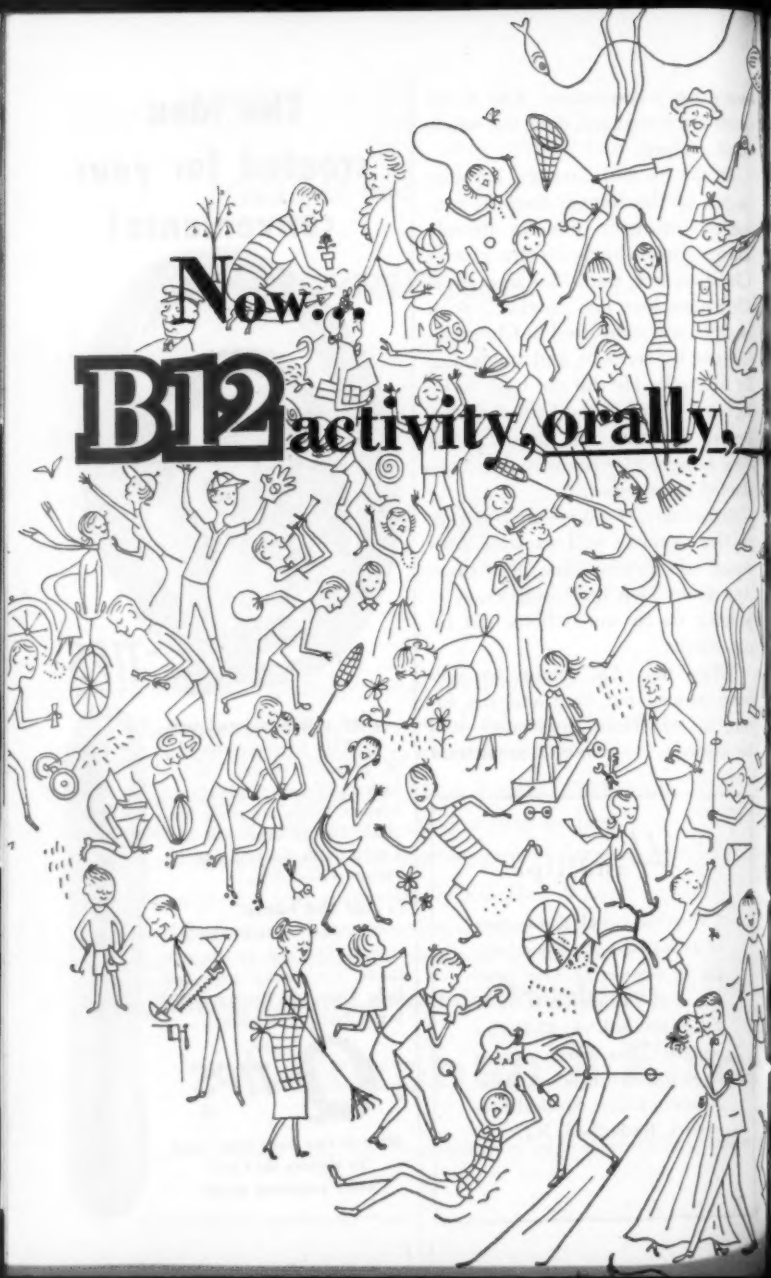
¶ What nontechnical procedure or device have you found helpful in conducting your practice more efficiently? MEDICAL ECONOMICS will pay $5-$10 for original ideas worth passing on to your colleagues. Address Handitip Editor, Medical Economics, Rutherford, N.J.



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Blood-Building Activity. *Positive hematinic response* is assured by the tonic quantities of ferrous gluconate, plus the important activity of vitamin B_{12}.

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Appetite-Building Activity. In addition to being the most important hematopoietic principle in liver, vitamin B_{12} appears to reinforce the action of other B complex factors in cellular metabolism and growth, and in rebuilding appetite.

Each ounce of pleasant-tasting Beta-Concemin Ferrated supplies the activity of 12 mcgm. of vitamin B_{12} as contributed by vitamin B_{12} concentrate augmented by a special fraction of liver, as determined by microbiological assay. Other B factors are present in excess of established minimum daily requirements.

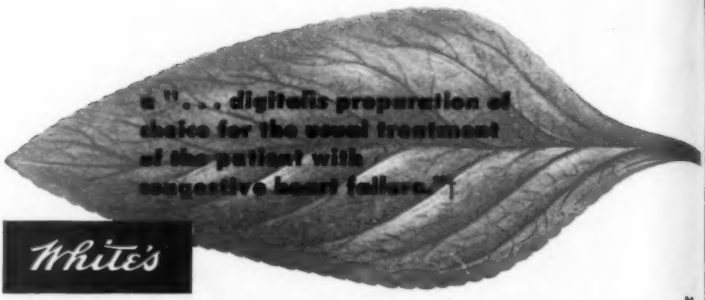
ELIXIR

BETA-CONCEMIN FERRATED

IRON B COMPLEX WITH B_{12} ACTIVITY

Merrell
1828
CINCINNATI • U. S. A.

[1] Reznikoff, P.: Med. Clin. N. Amer. 28:368, 1944.
[2] Teeter, E. J.: J. A. M. A. 127:976, 1945.
[3] Haden, R. L.: Principles of Hematology, Lea and Febiger, Philadelphia, 1940.
Beta-Concemin®



White's

GITALIGIN*

AMORPHOUS GITALIN—PURIFIED CARDIOACTIVE GLYCOSIDAL CONSTITUENT OF DIGITALIS PURPUREA

(ji-tal-i-jin)

In the above carefully chosen words, Batterman, DeGraff and coworkers† sum up their conclusions following a four-year controlled clinical study in approximately 230 cases.

PROVED CLINICAL ADVANTAGES

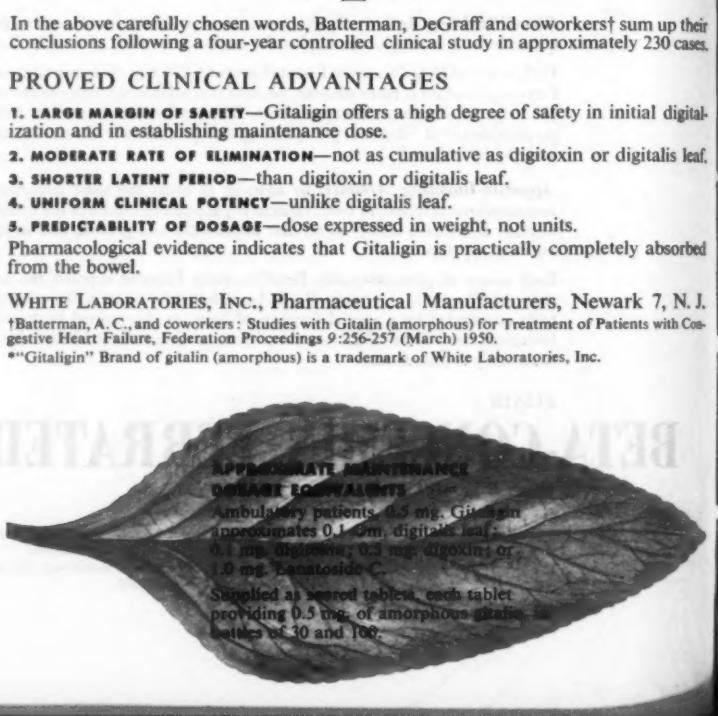
1. **LARGE MARGIN OF SAFETY**—Gitaligin offers a high degree of safety in initial digitalization and in establishing maintenance dose.
2. **MODERATE RATE OF ELIMINATION**—not as cumulative as digitoxin or digitalis leaf.
3. **SHORTER LATENT PERIOD**—than digitoxin or digitalis leaf.
4. **UNIFORM CLINICAL POTENCY**—unlike digitalis leaf.
5. **PREDICTABILITY OF DOSAGE**—dose expressed in weight, not units.

Pharmacological evidence indicates that Gitaligin is practically completely absorbed from the bowel.

WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N. J.

†Batterman, A. C., and coworkers: Studies with Gitalin (amorphous) for Treatment of Patients with Congestive Heart Failure, Federation Proceedings 9:256-257 (March) 1950.

*"Gitaligin" Brand of gitalin (amorphous) is a trademark of White Laboratories, Inc.



Every Hospital a Teaching Hospital!

[*Continued from* 58]

rectors of medical education in the local hospitals."

The men picked for this post were outstanding young physicians with three or four years' special training in internal medicine. Each served one year—sometimes singly, sometimes in pairs. Here are some of the familiar teaching-hospital devices which, beginning in July 1946, they successfully transplanted to the small hospitals on their beat:

Clinico-pathological conferences. Dr. Kaufmann helped get these started early in the game. Once a month in each hospital, staff clinicians met to discuss selected cases; the teaching resident added his comments; and the pathologist wound things up by presenting the laboratory verdict.

Death reviews were scheduled once a month in every hospital. Here the pathologist's complete post-mortem findings became part of the doctors' educational routine.

Staff audits. At Franklin County and Cooley Dickinson, monthly statistical analyses were set up. These audits sought to show, among other things, whether each operation had been justified. Questionable cases came in for searching group discussion.

Clinical conferences organized by the teaching residents were held weekly in each hospital. Cases presented for discussion included both medical and surgical, were especially slanted for G.P.'s. Guest speakers from the New England Medical Center frequently boomed attendance.

Free consultation services. The teaching residents planted the idea that they'd be glad to look at private patients on request. Frequently, local doctors responded by saying, "I've got an interesting case you might like to see." The resident looked—and sometimes was able to pass along useful clinical information to the consulting M.D.

Teaching ward rounds. "Here," says Dr. Robert P. McCombs of the Tufts College Medical School, "the teaching resident could impart his knowledge to local physicians at the point where it was most effective—the patient's bedside." At Cooley Dickinson, teaching rounds were staged every day; staff doctors took part in rotation. Elsewhere, such rounds were scheduled once a week, with a dozen or more doctors in on bedside discussions.

Two-Way Traffic

What about the third phase of the Bingham plan—the link between local hospitals and the New England Medical Center? It was established shortly after the first two phases. Twice a month, the pathologist, the teaching residents, and other local physicians (partic-

"... there is the fallacy still prevailing, that gout is a rare disease."

McNEIL LABORATORIES, INC. • PHILADELPHIA 32, PA.

†Finn, N., Brit. M. J. (Nov. 26) 1949

HE "OVER 40" ARTHRITIC

Many a case of painful arthritis in the "over 40" age-group—those most susceptible to gouty arthritis—will respond to Cinbisal.

Cinbisal combines colchicine with salicylate—both effective in producing urate diuresis and relieving arthritic pain. Inclusion of a protective dose of ascorbic acid assures adequate replacement of this essential factor during salicylate therapy.

EACH TABLET CINBISAL CONTAINS:

Colchicine.....0.25 mg. (1/250 gr.)
Sodium Salicylate.....0.3 Gm. (5 gr.)
Ascorbic Acid.....15 mg.

SUGGESTED DOSAGE:

One or two tablets every four hours.

SUPPLIED: Cinbisal is available in bottles of 100 and 1000 tablets (Engestic® coated green).

Samples on request.

CINBISAL*

'McNEIL'

*Trade-Mark of McNeil Laboratories, Inc.

prompt symptomatic relief in hay fever

Your hay-fever patient wants most of all the ability to breathe normally—so that he can eat and enjoy it, sleep and be rested, work and play unhandicapped. For him, you can recommend Benzedrex Inhaler and be virtually sure that it will free him promptly of hay fever's most annoying symptoms.

Benzedrex Inhaler has four outstanding advantages:

1. More rapid vasoconstriction
2. More prolonged vasoconstriction
3. Clean, medicinal odor
4. No excitation or wakefulness

Smith, Kline & French Laboratories, Philadelphia

Benzedrex Inhaler

the best inhaler ever developed

'Benzedrex' T.M. Reg. U.S. Pat. Off.

ularly X-ray men*) trekked to Boston for a full day of idea-trading, consultation services, or brief refresher courses ranging from diabetes to general medicine. In the opposite direction came big-city specialists who'd been invited to add their bit to the medical knowledge of the local staffs. The Bingham Fund picked up travel tabs.

Thus began a $150,000 experiment in improving small-town medical care. Has it succeeded? Has it helped local medical men keep up with clinical progress? Has it meant better service for more patients?

Perhaps the most revealing answer is this: Local people have now taken over the program and are running it largely on their own. Bingham support has been mostly withdrawn. The plan stands on its own feet—and is enthusiastically supported by doctors and hospitals alike.

Look at the central pathology lab. It's grown into a diagnostic mainstay for physicians in the region. It has a capable new chief (Dr. Jogindar S. Grewal), an enlarged headquarters (at Holyoke Hospital), an expanded staff (two residents, two tissue technicians, a bacteriologist, and a secretary). Seven hospitals now share its services, the newcomers being three smaller hospitals in the area: Noble, Wing, and Mary Lane.

To support the lab, each hospital pays $8 per tissue examination plus graded monthly fees ($100-$250) for autopsy and advisory services. Lab income has hit $5,000 a month and is still going up. So is the standard of service, under the direction of a local management committee comprising four hospital trustees.

It's a different story with the teaching resident idea. "In all frankness," says Dr. Myles Illingworth, who used to be one, "this phase of the Bingham program has failed." Yet there's more to it than that:

The training activities touched off by the teaching residents are today being carried on by local doctors. Though the residents are gone, the things they helped start—the CPC's, the weekly clinical sessions, the staff consultations, the teaching rounds—still go on. That alone makes the idea more plus than minus.

But there's no question about it: The teaching resident's job raises a knotty problem in diplomacy. A well-trained young doctor can often help a well-experienced older doctor, yet it takes a deft touch. "In theory," says one man, "the idea is excellent. In practice, it runs counter to human nature—particularly to medical human nature in New England."

But this wasn't what wrote finis to the experiment. The mounting house-staff shortage took care of

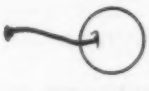
*Western Massachusetts had a full quota of good private radiologists. In other areas where local hospitals have lacked such services, the Bingham Association Fund has helped set up a cooperative radiological plan.

New

Terrabon

Brand of Terramycin Elixir

Provides: Terramycin: 250 mg. per teaspoonful (5 cc.)



cherry-color appeal

mint flavor

TERRABON,* presents the only broad-spectrum antibiotic available as an elixir and in such potency. Since 1 teaspoonful (5 cc.) is equal in Terramycin content to one 250 mg. capsule, *therapy with the elixir does not require new and unwieldy dosage schedules.*

the preferred dosage form for

- Pediatric Patients
- Geriatric Patients
- "Sensitive" patients who experience difficulty in taking the customary forms of oral antibiotic medication.

unique

The *palatability and pharmaceutical elegance* of TERRABON *add appeal* to the *broad antimicrobial activity, wide clinical effectiveness,* and *high toleration* of

Terramycin—newest of the broad-spectrum antibiotics.

Terrabon Dosage: One teaspoonful (5 cc.) of Terrabon is equal in Terramycin content to one 250 mg. capsule. In adults and older children, 2 to 3 Gm. daily in divided doses q. 4 or 6 h. is suggested. In children under 20 Kg. body weight, suggested dosage is 100 mg./Kg. body weight per day.

Supplied: Terrabon is available as a combination package consisting of:

1. A vial containing 1.5 Gm. of Terramycin as Terramycin Hydrochloride.
2. A bottle containing 1 fluid ounce of specially buffered and flavored diluent.

Also Available: Crystalline Terramycin Hydrochloride in 3 convenient capsule sizes:

250 mg., bottles of 16 and 100;
100 mg., bottles of 25;
50 mg., bottles of 25.

Pfizer

Antibiotic Division
CHAS. PFIZER & CO., INC., *Brooklyn 6, N.Y.*

*Trade Mark

that. A couple of years ago, each hospital in Western Massachusetts had two to four house officers. Today most have none.

When he has no internes or residents to ride herd on, the usefulness of the teaching resident declines. Says Dr. Herbert Perkins, the 1949-1950 incumbent: "One of the best ways to teach local doctors is through the house staff. If a couple of internes are sitting up front at a teaching conference, the local doctors won't mind dropping in. They'll feel much less like attending if the instruction is aimed directly at them."

Though the teaching resident posts won't be filled in 1950-1951, the Bingham people hope to make up for it by arranging attractive post-graduate work. Says Dr. McCombs: "Many local doctors are already making use of consultation services at the Medical Center in Boston. Starting in July, a few surgeons from Franklin County Hospital will come here once a week to work in the department of surgery under medical center supervision. Thus they'll get continued training without having to give up practice."

Whatever its minor setbacks, the Western Massachusetts experiment is paying off. By all the signs—diagnostic work, surgical skill, use of new techniques, interest of local physicians—medicine in that region has been perceptibly jacked up.

"Even the patients realize it," says William Dwyer, a trustee of Cooley Dickinson Hospital. "Take our own community. In the old days, many people would never think of having certain major operations done here in town. If they could possibly afford it, they'd travel to the nearest big medical center. Today more and more patients are having their operations done locally. That means more paying patients for the hospital, more work for the doctors."

Adds William Lees Jr., administrator of the Cooley Dickinson Hospital: "The ultimate benefits to the patient, both in better medical care and in keeping costs from being excessive, are obvious to everyone."

Says Paul F. Nalon, director of the Franklin County Public Hospital: "This program has elevated professional standards all along the line."

• • •

Make *every* hospital a teaching hospital?

Not literally, perhaps; for the spark has to come from within. Yet even without philanthropic aid on the Western Massachusetts scale, small-town hospitals can club together. They can share the major elements of a big-time teaching program that none alone could afford. All it takes is *regional thinking* and *regional action*.

Don't be surprised if small-town doctors begin to take the lead in this sort of thing. They stand to reap almost as many benefits as the patient. —EDWARD E. RYAN

"one keep-clean is better than ten make-cleans"

Bactine *makes clean*—Effective against most pathogens, including at least 14 common pathogenic fungi, *Bactine* makes skin, clothing, glass, metal, plastic and enamel surfaces surgically clean.

Bactine *keeps clean*—Remaining after application as invisible protection, *Bactine* keeps whatever it disinfects—hands, mask, instruments, thermometers, etc.—antibacterial for up to six hours despite re-contamination.

in addition

Bactine *is* . . .

A Superior Cleanser-Deodorant—A true deodorant, *Bactine* doesn't mask but eliminates odors and destroys the bacteria responsible for them,

Surface Active—*Bactine* lifts off and removes dirt, penetrates minute cracks and crevices,

An Effective Anti-irritant—Mildly cooling and anesthetic, it provides rapid relief of itch from skin irritations, sunburn, insect bites, etc.,

Gentle and Non-drying to the Skin and practically painless even on abrasions and cuts.

for office, hospital, home and personal use

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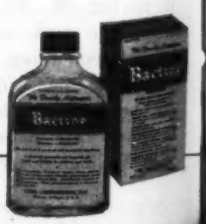
ideal antiseptic, bactericide, cleanser-deodorant and fungicide

Bactine, a clear, colorless liquid with a clean, fresh odor, will take on hundreds of jobs for you and do them well. A comprehensive brochure on *Bactine* is available on request.

Active Ingredients: Di-isobutyl cresoxy ethoxy ethyl dimethyl benzyl ammonium chloride, polyethylene glycol mono-iso-octyl phenyl ether, chlorothymol, alcohol 4%.

Inert Ingredients: Water, propylene glycol, essential oils. Total inert 95%.



MILES LABORATORIES, INC • ELKHART, INDIANA

The Law and Your Prescriptions

[*Continued from* 60]

"Even assuming that the patient understands, there's always the possibility of the pharmacist's confusing words like, say, calamine and calcium. In one well-known case, the doctor called for a lotion containing 'mild chloride of mercury' but the pharmacist heard it as 'bichloride of mercury.' The jury found against the doctor, not against the pharmacist; for over the telephone the terms are readily confused; and if anything at all goes wrong with a telephoned prescription, the doctor is vulnerable.

"A physician might be considered negligent without proof of any other carelessness at all. The mere fact that he entrusted a prescription to anything as ephemeral and as easily confused as a spoken order, might well stamp him as negligent."

My friend took another look at the prescription in his hand. There was a blank for "age" just after the space for the patient's name. I had not written in his age. I hardly ever do. Pointing to the blank, he asked:

"Might a certain dose be harmless to an adult, toxic to a child, perhaps fatal to a baby?" I agreed that with some medications, this could be true.

"That, I suppose, is why a space for the patient's age is printed on most Rx blanks. By failing to write in the age, you deprive yourself of the chance of sharing responsibility with the pharmacist if something goes wrong.

"If a druggist fills a prescription calling for what amounts to an overdose for a child, the druggist may well be in the clear if the doctor has failed to indicate the patient's age. For who was to know the Rx was for a child? The only safe method is always to write in the patient's age."

"While you're in the mood for a legal lecture, how about the state and federal narcotic laws?" I asked. "Last year, as you know, I moved my office across the street. Believe it or not, I got a call from the Collector of Internal Revenue. He said my dollar-a-year tax stamp authorized me to prescribe narcotics from an office at 25 Maple Street but not from one at 28 Maple Street. He said I should have notified him before I actually moved so that he could amend the tax stamp. Did you ever hear of such nonsense?"

"The collector was right. Narcotic rules have to be followed strictly. You're dealing with something that has big-time criminal potentialities. The only safe way is to follow the regulations literally and scrupulously. I don't know much about the Harrison Act, but I have a colleague who works in the U.S. Attorney's office. Let me check with him and I'll send you a note."

A few days later, my lawyer-pa-

now

peptomatic* digestional aid in single tablet form

By developing an entirely new type of enzymatic carrier, literally "a tablet within a tablet," Robins now makes available a triple-enzyme digestant—Entozyme. In *one small specially constructed tablet*, Entozyme "packs" pepsin, pancreatin and bile salts—in such a way that they are released only at the gastro-intestinal level of optimal activity. Thus Entozyme greatly simplifies and makes more effective the treatment of complex digestive disturbances of the gastro-intestinal tract. Clinical studies[1,2,3] have demonstrated the value of Entozyme in such conditions as chronic cholecystitis, chronic duodenal ulcer, acute and chronic pancreatitis and certain postoperative syndromes of the gastro-intestinal tract—in relieving nausea, belching, distention, anorexia, food intolerance, etc.

FORMULA: Each specially constructed tablet contains Pancreatin, U.S.P., 300 mg.; Pepsin, N.F., 250 mg.; Bile Salts, 150 mg.

DOSAGE: One or two tablets after each meal, or as directed by physician, without crushing or chewing.

AVAILABLE: Bottles of 25 and 100.

REFERENCES:

1. Kammandel, N. et al.: Awaiting publication.
2. McGavack, T. H. and Klotz, S. D.: Bull. Flower Fifth Ave. Hosp., 9:61, 1946.
3. Weissberg, J., McGavack, T. H. and Boyd, Linn J.: Am. J. Digest. Dis., 15:332, 1948.

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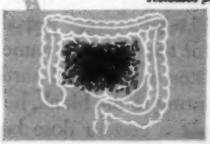
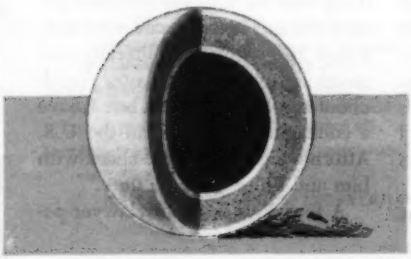
Ethical Pharmaceuticals of Merit since 1878

The "Peptomatic" Tablet

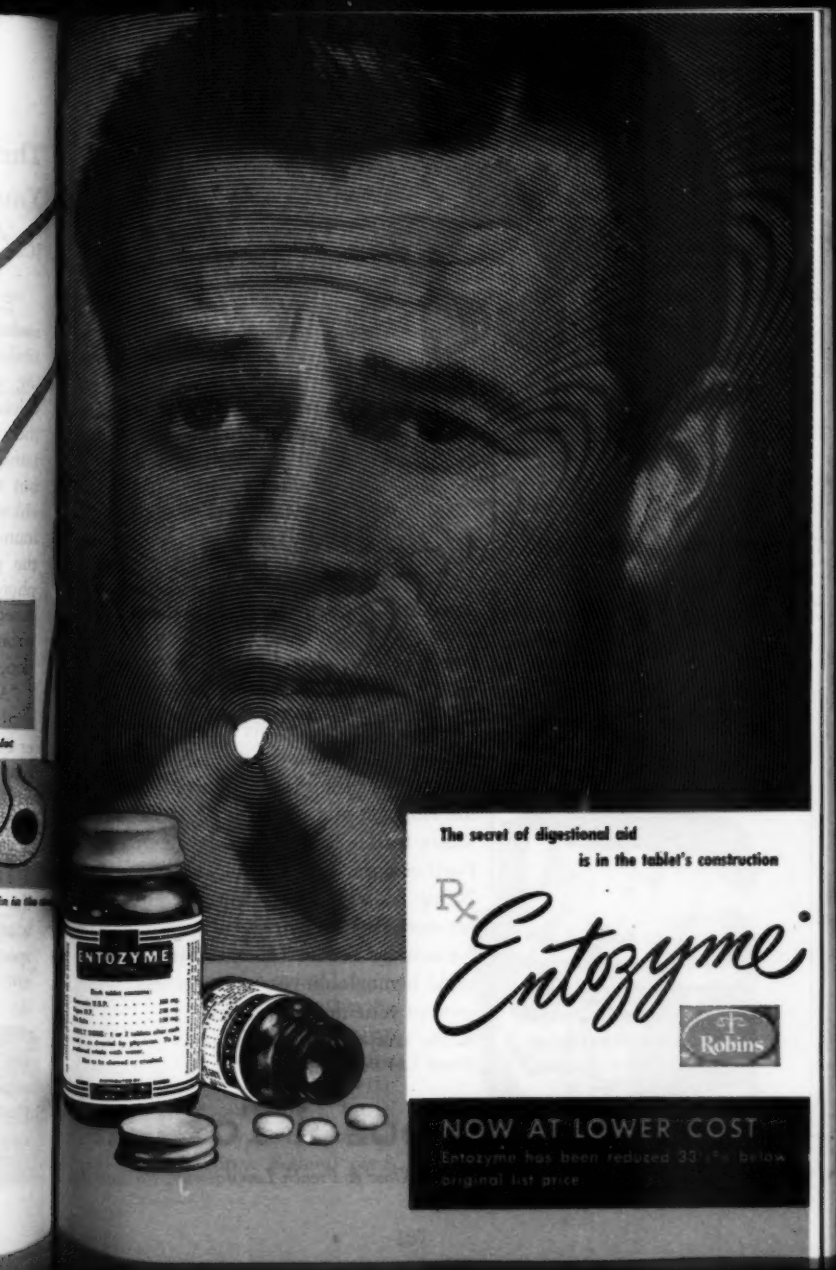
Releases pepsin in the



Releases pancreatin and bile salts in the small intestine



**The "Peptomatic" Tablet*—
a coined word to describe the unique mechanical action of Entozyme Tablet.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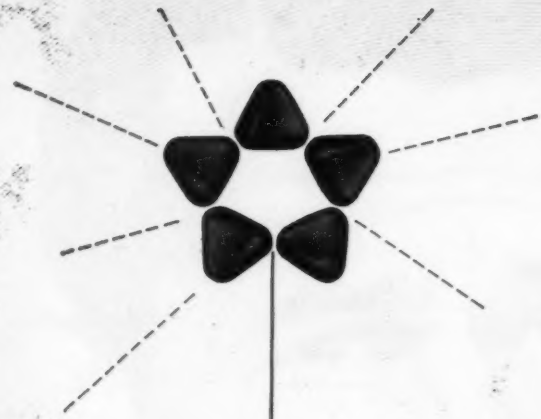
The secret of digestional aid
is in the tablet's construction
℞ Entozyme
Robins
NOW AT LOWER COST
Entozyme has been reduced 33⅓% below
original list price



...the "magic" of the coating...

another reason why Feosol Tablets are the standard iron therapy

Feosol Tablets' specially developed coating insures *timed disintegration* of the tablet in the acid medium of the stomach and upper duodenum, where iron is best absorbed. Furthermore, each Feosol Tablet supplies 20 mg. blood-building iron per grain—*far more than ordinary iron preparations.* No wonder Feosol Tablets effect such rapid hemoglobin regeneration and prompt reticulocyte response in the iron-deficient patient.

'Feosol' T.M. Reg. U.S. Pat. Off.

Each Feosol Tablet contains 3 grains exsiccated ferrous sulfate, equivalent to approximately 5 grains crystalline ferrous sulfate.

Feosol Tablets

Smith, Kline & French Laboratories, Philadelphia

tient sent me the following memorandum:

"They tell me that some doctors are pretty casual about the way they prescribe narcotics. No wrong is intended, but they sometimes embarrass both themselves and the bureau. The collector doesn't want to make trouble for any honest doctor. But the honest doctor sometimes makes it hard for the collector. For instance:

"In writing the Rx, you have to be sure that your registry number appears. It's printed on the Rx letterhead so that's usually no problem. But once in a while you write a prescription in a hospital or clinic, or under some circumstance where you use a blank sheet. Remember that your number must be written in then.

"Another thing:

"Most doctors write in the patient's name on the Rx blank, but lots of them forget to write the patient's *address*. If later any question arises, the bureau wants to be able to locate and identify the patient. So make sure his address is included.

"Some doctors phone a pharmacist, tell him they're sending the patient's brother down to the drugstore to pick up some opiate, promise to drop in with the written Rx the first thing tomorrow morning. That puts the pharmacist on the spot. He wants your goodwill, wants to help your patient. But if he does it that way, he lays himself open to a term in a Federal penitentiary. In extreme urgency, the physician may telephone the pharmacist, ask him to deliver the drug to the patient's home. But the written Rx must be handed to the messenger when the medication is delivered. If the prescription is not available then, the pharmacist is absolutely right in refusing to hand over the drug.

"Here's another point many physicians forget:

"For two years after the doctor issues any narcotic-containing prescription he must keep a record of it. He may enter this on the patient's record card; or he may prefer to keep a special book of prescription duplicates. But he *must* have a permanent record somewhere showing every opiate or coca leaf Rx issued, with the quantity, dose, diagnosis, and name and address of each patient on whose behalf the prescription was issued.

"Many states have their own

statutes covering opiates, cocaine derivatives, marijuana or barbiturates. The Harrison Act, a Federal law, gets most of the publicity; but every practitioner ought to check locally to see if there are special formalities required by state law or city ordinance.

"I was surprised to learn how many medical bags are stolen or rifled every month. Leaving the bag on the seat of even a locked car is an open invitation to the drug peddler, since the bag is visible through the car window. The smart M.D. carries his bag with him when he parks his car. This saves him an uncomfortable half hour with the revenue agents when he has to explain how morphine tablets registered to him were stolen and found their way into illegal traffic.

Rx's Forged

"I was also astonished at how many forged prescriptions turn up annually. It must be embarrassing to have the bureau cross-examine you when an addict has been getting supplies on your Rx blanks. You're perfectly innocent: The signatures were forged; and there was no attempt to mimic your signature. But the bureau can't help wondering if you have been lax with your prescription blanks.

"I know you keep a pad on the top of your desk. Seems natural to do so. Yet any casual visitor can tear off a few sheets when your back is turned. I was told of one physician who used Rx blanks for bridge scores. He said he got them free from a local pharmacist and, from his viewpoint, the blanks could thus be used as freely as scrap paper. There was even one case where a housewife wrote orders to the milkman on her doctor-husband's prescription blanks. She inserted a note into the neck of an empty milk bottle on her back porch every morning."

* * *

Over the past few years, several of my colleagues have been sued for malpractice. None of these cases concerned prescriptions. In one case there was the question of whether a scalpel had slipped. Another case was based on an alleged X-ray burn. But the slipping of a scalpel or the burning of skin are bits of evidence that vanish. They can be explained away or, if appropriate, denied. They are here today, gone tomorrow. Reasonable people can honestly disagree about their severity and their implications.

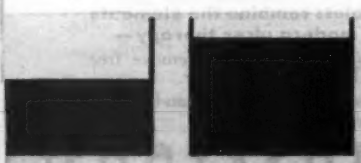
A prescription is quite different. Once issued, it passes beyond the control of the signer. If there is anything wrong with it, it gets a permanent place as a piece of evidence against the doctor. It is conspicuous, concrete, eloquent, and immortal. Since for all time it will bear the signer's name, it is perhaps the better part of wisdom to be cautious and deliberate before putting so permanent a document irrevocably into circulation. My legal friend, I'm forced to admit, is right.—WILLIAM MAC DONALD, M.D.

new! **IMPROVED**

54% more bulk with

"Plancello" Tablets, the new improved bulk laxative tablets, supply a maximum amount of effective, soft, moist lubricating bulk in a minimum dosage form without causing bloating or abdominal discomfort.

54% more bulk . . . in "Plancello" Tablets, 25% Plantago loeflingii — a superior bulk producing agent — has been added to 75% methylcellulose, thus providing 54% more bulk than methylcellulose alone. The increased bulk adds to the water-binding properties of "Plantago" and in this way assures more effective results.



On a gram for gram basis, "Plancello" Tablets form 54% more bulk than equivalent amounts of methylcellulose alone.

smaller dosage . . . increased bulk makes possible smaller dosage and therefore better patient cooperation. Only 6 tablets daily are required as a starting dose and this may be reduced gradually as a return to normal physiologic function is noted.

PLANCELLO

TRADE MARK

BULK LAXATIVE IN tablet FORM

smaller dosage

Vitamin B₁ . . . has been added to "Plancello" Tablets to improve muscle tone and to enhance peristaltic action. The daily dose of 6 "Plancello" Tablets provides twice the minimum daily adult requirement of Vitamin B_1.

economy . . . the smaller dosage of "Plancello" Tablets reduces the cost of therapy for the patient.

Dosage: only 2 tablets after each meal (6 tablets daily) to be followed by one or preferably 2 glasses of water.

Supplied: 9.0 gr. tablets in bottles of 50 and 500.

Generous supply of samples on request.

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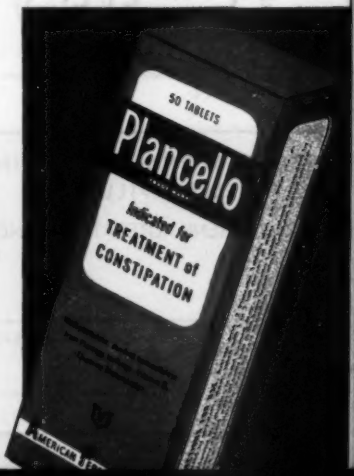

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The Stuart
THERAPEUTIC
B Complex and C

Extra-high B Complex and C potencies[1]
(natural B Complex from liver fraction)

Each Stuart Therapeutic B Complex, C tablet standardized to contain:

Ascorbic Acid	**150 milligrams**
Thiamin Chloride	**20 milligrams**
Riboflavin	**10 milligrams**
Pyridoxin Hydrochloride	**5 milligrams**
Niacin Amide	**150 milligrams**
Calcium Pantothenate	**10 milligrams**

Also other members of the B complex as present in liver fraction, including identified and unidentified B factors.

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COST
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PATIENTS

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[1]*Potencies and balance cover latest standards for multiple therapeutic dosage. 1. Rehabilitation Through Better Nutrition,* 1947–Spies. *2. Journal of American Medical Association,* Oct. 27, 1945; 129:613–Jolliffe. *3. Vitamin Deficiencies: Stigmas, Symptoms and Therapy* (J. A. M. A., June 22, 1946; 131:666–Council on Foods and Nutrition).

Library Service by Mail

How and where to get the clinical literature you need on any subject

• Dr. Ernest Reece, just out of interneship, had set up practice in a small Iowa town. He'd joined the county medical society and had courtesy privileges at the local hospital. Then he got what looked like an obscure case.

A paper about it, he decided, might establish him more firmly with the local profession. Who knows? It might even help get him on the hospital's attending staff.

The case involved an extreme blood reaction, amounting to leukemia, from a single sulfa dosage. Dr. Reece knew that a prolonged sulfa regimen could do this, but had never heard of its happening after one dose. He queried the hospital pathologist, who had never heard of it either. He too thought the case worth reporting—if the literature showed it rare or unique.

Dr. Reece began his research by addressing a request to the library of the American Medical Association. He asked for "whatever material you have on pathological effects of the administration of sulfa drugs, plus a bibliography on the subject." He enclosed the required 25 cents in stamps.

Ten days later, he got a bulky package of reprints and journals. Some dated back ten years, the time-coverage limit of the AMA service. Only publications in English were included. A covering letter explained that the AMA prepared no bibliographies, but that a short list of recent books was enclosed.

(Says AMA Librarian Magdalene Freyder: "We can be much more helpful when a doctor tells us just what he wants the material for—that is, whether he's involved in a law suit, or is writing an article, or seeks information on how to handle a particular case.")

Dr. Reece found nothing in the AMA material to suggest that his case *wasn't* unique. But he knew his digging had only begun. He took some notes, then mailed the package back within the ten-day time limit.

Help From the Army

Next he sent a letter to the Army Medical Library, Seventh Street and Independence Avenue, S.W., Washington 25, D.C., again requesting a bibliography. In reply,

poise . . .

. . . in women, is usually a synthesis of both physiological and psychological equilibrium.

The ability of TYREE's Antiseptic Powder to restore physiological equilibrium or to overcome many common pathological conditions stresses the value of professionally recommending this ethically promoted douche powder.

The detergent action of TYREE's Antiseptic Powder assures thorough cleansing in routine hygiene and its cooling essential oils afford a soothing sense of relief to delicate membranes. In pathological conditions, this powerful but gentle antiseptic easily destroys most ordinary intruders. In either situation, TYREE's low pH helps restore and maintain the normal protective acidity of the healthy vagina.

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TYREE'S ANTISEPTIC POWDER

In bottles of 2 ozs. 4 ozs. 8 ozs.

J. S. TYREE, CHEMIST, INC.
15th and H Streets, N.E., Washington 2, D. C.
Makers of CYSTODYNE, a Urinary Antiseptic

he got a brochure detailing the AML's services, plus a letter referring him to the medical library of his state university, thirty miles distant. This was his nearest access, the AML advised, to its "Current List of Medical Literature," a cumulative, world-wide index of journal articles.

While AML service was available to all U.S. physicians, the letter pointed out, they were expected first to exhaust the resources of their local libraries. Moreover, the doctor could borrow from the AML only through his own public, hospital, or university library, on an inter-library loan basis. The AML would be glad to prepare him a bibliography, if he would consult his own library first.

World's Largest Library

From the brochure, Dr. Reece learned that the AML medical collection was the world's largest—400,000 books, 534,000 pamphlets, 8,000 photos; microfilm strips from some 2,000 journals. Other AML services: low-cost photo-duplicating, a registry of qualified translators.

The Army Medical Library makes no charge, other than shipping costs, for borrowed material. Its subject matter covers medicine, nursing, pharmacy, and allied fields. Material may be kept up to two weeks. Only books published since 1860 are issued on loan.

At this point, the doctor learned that the Iowa State Medical Library operated a mail service, free to Iowans. (For other state medical libraries, medical societies, and medical schools offering package services within their respective states, see list following this article.)

He wrote to Des Moines, got back eight books, a bibliography, and fifteen journal articles. All but two of the latter (from foreign journals) were duplications of the AMA material.

He went over the new literature, still spotted no sulfa-reaction case similar to his own. He mailed back the package, canceled a Saturday golf date, and drove over to the state university. There he turned his indubitable charm on a tittery young librarian, who promptly dug up everything in the place and sent to the Army Medical Library for still more volumes.

Other Package Services

Dr. Reece, for future reference, consulted the head librarian about other national package services. She named four, all in specialty fields:

American College of Surgeons. Service is to members only. Reprints, periodicals, bibliographies, low-cost translations covering both medicine and surgery. Two-week lending period. Charge: return postage only.

American Cancer Society. "Index of Neoplastic Diseases," a complete listing of cancer literature throughout the world. Bibliographies, re-

prints, special queries answered. Two-week lending period. Charge: return postage only.

American Heart Association. Not a lending service, but distributes clinical literature (periodicals, reprints) on request; also suggests references. No charge.

National Foundation for Infantile Paralysis. Reprints only. No charge.

Ernest Reece finally completed his paper, taking three months all told, instead of the two weeks he'd figured on. But he was able to state truthfully that an "exhaustive search of the literature" had revealed only one similar case, eight years before, in Australia. His paper appeared as a note in his county journal.

A few months later, he was invited to join the attending staff of his local hospital. The paper *might* have had something to do with it. Or it might have been no more significant than the fact he had recently become engaged to the daughter of one of the hospital trustees.

* * *

The following libraries offer mail services within their respective states. Some require lending cards, others have other restrictions—but all welcome inquiries.

ALABAMA: Medical College of Alabama Library, Birmingham.

ARIZONA: State Medical Association, Phoenix.

CALIFORNIA: Los Angeles County Medical Association Library; University of California Medical Center Library, San Francisco; College of Medical Evangelists Library, Loma Linda; School of Medicine Library, University of Southern California, Los Angeles; Lane Medical Library, Stanford University, San Francisco.

COLORADO: State Medical Society, Denver.

CONNECTICUT: Yale Medical Library, New Haven.

DISTRICT OF COLUMBIA: School of Medicine Library, Howard University, Washington.

FLORIDA: State Board of Health Library, Jacksonville.

GEORGIA: Calhoun Medical Library, Emory University, Atlanta.

ILLINOIS: State Medical Society, Monmouth.

INDIANA: School of Medicine Library, Indiana University, Indianapolis.

IOWA: State Medical Library, Des Moines; University of Iowa Medical Library, Iowa City.

KANSAS: School of Medicine Library, University of Kansas, Kansas City.

KENTUCKY: State Medical Association, Louisville; Medical Reference Library, State Department of Health, Louisville; Jefferson County and University of Louisville Medical Library, Louisville.

LOUISIANA: State Department of Health Library, New Orleans; Orleans Parish Medical Society Library, New Orleans; School of Medicine Library, Louisiana State University, New Orleans; Rudolph Matas Medical Library, Tulane University, New Orleans. [*Turn page*]

Help For Your OBESITY Problems

You can save *many hours of consultation time*—help overweights reduce safely and maintain normal weight after reduction—with these free *booklets for patients*:

"LOW-CALORIE DIETS"—1200 calories for women; 1800 for men.

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All diets are carefully balanced to supply essential nutrients. Psychological factors are considered. *Correct* eating is encouraged. Thus the lasting benefits of "stay slim" habits are acquired.

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E-L Checkerboard Square, St. Louis 2, Missouri

Please send (indicate quantity):

_____C3049 "Low-Calorie Diets"—for adults—Imprinted? Yes_____ No_____

_____C966 "Through the Looking Glass"—for teenage girls.

Name_____M.D.

Street_____

City_____Zone_____State_____

MARYLAND: Medical and Chirurgical Faculty of Maryland, Baltimore; University of Maryland School of Medicine Library, Baltimore.

MASSACHUSETTS: Boston Medical Library.

MICHIGAN: University of Michigan Medical Library, Ann Arbor.

MINNESOTA: State Medical Association, St. Paul.

MISSISSIPPI: State Board of Health Library, Jackson; Rowland Medical Library, University of Mississippi School of Medicine, Oxford.

MISSOURI: University of Missouri Medical Library, Columbia.

NEBRASKA: State Medical Association, Lincoln; College of Medicine Library, University of Nebraska, Omaha; Creighton University School of Medicine and College of Pharmacy Library, Omaha.

NEW JERSEY: State Medical Society, Trenton.

NEW YORK: Medical Society of the County of Kings Library, Brooklyn; School of Medicine Library, University of Buffalo, Buffalo; College of Medicine Library, Syracuse University, Syracuse; New York State Medical Library, Albany.

NORTH CAROLINA: Duke Hospital Library, Durham.

NORTH DAKOTA: State Health Department Library, Bismarck; Medical Library, University of North Dakota, Grand Forks.

OHIO: Cleveland Medical Library Association; School of Medicine Library, Western Reserve University, Cleveland.

OREGON: Medical School Library, University of Oregon, Portland.

PENNSYLVANIA: State Medical Society, Harrisburg; Philadelphia College of Physicians Library, Philadelphia; Luzerne County Medical Society Library, Wilkes-Barre; Philadelphia County Medical Society Library; Pittsburgh Academy of Medicine Library; School of Medicine Library, Temple University, Philadelphia; Woman's Medical College Library, Philadelphia.

RHODE ISLAND: State Medical Society, Providence.

SOUTH CAROLINA: State Medical College Library, Charleston.

SOUTH DAKOTA: Medical Library, University of South Dakota, Vermillion.

TENNESSEE: Medical School Library, University of Tennessee, Memphis; School of Medicine Library, Vanderbilt University, Nashville.

TEXAS: State Medical Association, Austin; Baylor Medical-Nursing-Dental Library, Dallas; Southwestern Medical School Library, University of Texas, Dallas; Medical Branch, University of Texas, Galveston.

UTAH: Medical Library, University of Utah, Salt Lake City.

WASHINGTON: Medical-Dental-Nursing Library, University of Washington, Seattle.

WISCONSIN: Medical Library Service, University of Wisconsin, Madison. END

This Press Code Really Pays Off

One medical society finds a formula for building good public relations

● "You can't assume that doctors instinctively know how to deal with the press. Or that newsmen are devoted to furthering the best interests of the medical profession. What's needed is a consciously formulated policy."

So says Dr. McKinnie L. Phelps of the Colorado State Medical Society. And he speaks from experience. As far back as 1947, leaders of the Colorado group learned that a go-as-you-please policy is no policy at all. Determined to give some direction to their press relations, they called a meeting with newspaper and radio men.

"This wasn't a conference with journalistic brass," says Dr. Phelps. "Our physicians sat down with the men who actually write and edit the news."

Nor were any punches pulled. Doctors objected to loose reporting and sensationalism. Newsmen countered by showing how these defects were aggravated by lack of information.

The major complaint of the press was about delay in getting news from medical sources, particularly in emergencies. A typical example was the reluctance of doctors to give a prognosis when a celebrity was ill or injured. "We don't want a case history," said one reporter, "but surely you know if the guy's O.K. or dead."

From this give-and-take session came the Colorado Code of Cooperation.* Its basic aim: to give doctors and hospitals a set of guiding principles for dealing with the press.

Early reaction to the code was mixed. Most doctors favored it. Some thought it unnecessary. A few said it wouldn't work. Apparently, the skeptics were way off base. For, today, there's proof that the code is a whopping success.

24-Hour Service

Thanks to the information bureau maintained at state society headquarters, medical news reports in Colorado are now almost 100 per cent accurate. Regardless of when a story breaks, reporters can check the facts with authorized physicians. A big hit with newsmen, this round-the-clock service insures both

*The code was first described in "The Quotation of M.D.'s by the Press," Sept. 1948 issue.

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the profession and the public against garbled news stories.

The Code of Cooperation has meant good-by to the physician's old taboo against being quoted. Doctors who once were so cautious that they refused to give an accident patient's name have loosened up and are now giving newsmen a break. And reporters know where to draw the line between legitimate news and what's none of their business.

Medical news coverage is not only better, it's bigger. One reason is that quotes from responsible doctors often make a story of an item that would otherwise fall flat. For example, a nation-wide wire report about a new drug gains point when the medical society gives a local angle to it.

The Basic Principles of the Col

★ ★ *Press and Radio* ★ ★

1. Representatives of the press and radio shall cooperate by refraining from any action or demand that might jeopardize the patient's life or health.

2. When a physician or hospital authority is quoted directly and by name, representatives of the press and radio shall make certain to the best of their ability that the quotation is accurate both in content and context.

3. Representatives of the press and radio shall exercise editorial judgment to avoid publishing material solely to exploit the patient, doctor, or the hospital.

4. On all matters of health or medical news, representatives of the press and radio shall make all reasonable efforts to obtain authentic information from the qualified sources indicated above before proceeding to publication or broadcast.

★ *The Medical Society* ★

1. The executive offices of the Colorado State Medical Society shall be available at all times to representatives of the press and radio to obtain authentic information as promptly as possible on health and medical subjects.

2. Officers, committee chairmen, or designated spokesmen of the society may be quoted by name in matters of public interest for purposes of authenticating information given.

3. County and regional medical societies in Colorado have been urged to adopt a similar policy.

4. In matters of private practice

What's more, medical news is no longer buried in the back of the newspaper. The society's information bureau sees to it that spot news elbows its way into a favored position in the front section.

There hasn't been a serious hitch since the code went into effect. One good reason for this harmony is that reporters and physicians now air their gripes at semi-annual get-togethers. There, straight-from-the-shoulder talk eliminates any friction points.

The camaraderie of these sessions is surprising. One was sponsored jointly by Denver's two leading newspapers. Their editors, although keen rivals, saw eye-to-eye when it came to continuing friendly relations with Colorado doctors.

Evan A. Edwards, the medical

Colorado Code of Cooperation

the wishes of the attending physician shall be respected as to use of his name or direct quotation. But he shall give information to the press and radio (where it does not jeopardize the doctor-patient relationship or violate the confidence, privacy, or legal rights of the patient) as follows:

¶ In case of accident or other emergency: the nature of the injuries, when ascertained; the degree of seriousness; and the probable prognosis.

¶ In cases of illness of a personality in whom the public has a rightful interest: the nature of the illness; its gravity; and the patient's current condition.

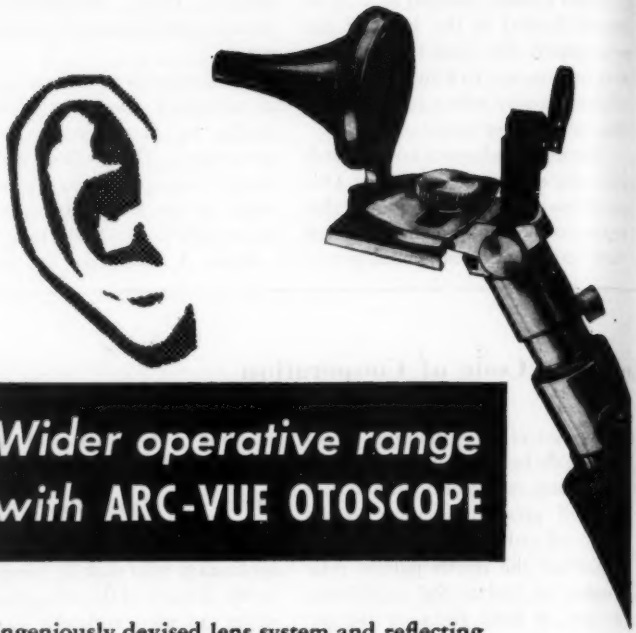
¶ In cases of unusual injury, illness, or treatment: the above facts plus any scientific information that will lead to a better public understanding of the progress of medical science.

★ ★ ★ ***Hospitals*** ★ ★ ★

1. Each hospital shall designate spokesmen who shall be competent, in the absence of the attending physician, to give authentic information to press and radio in emergency cases without clearance from higher authority.

2. In non-emergency cases, in the absence of the attending physician, hospitals shall provide information as outlined in Section 4 above.

3. Where information is given on hospital procedure, equipment, facilities for treatment, or other features of hospital service, authorities shall be careful not to imply that such facilities exist only in the hospital named unless that is the ascertained fact.



Wider operative range with ARC-VUE OTOSCOPE

Ingeniously devised lens system and reflecting prism permits rotation of speculum mount to give 36% larger operative field than similar instruments. Concentrated lamp filament and total reflecting prism projects brilliant white light through speculum to field. Head includes tongue depressor holder. Attractively cased with 4 specula, including nasal.

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OPTICAL COMPANY ROCHESTER 2, N.Y.

society's public relations director, says another factor in the code's success is the society's view that "cooperation is a two-way street." Some examples:

¶ When a small-town hospital released some news only to the local paper, the publicity chairman stood up for the radio station so it would not again be discriminated against.

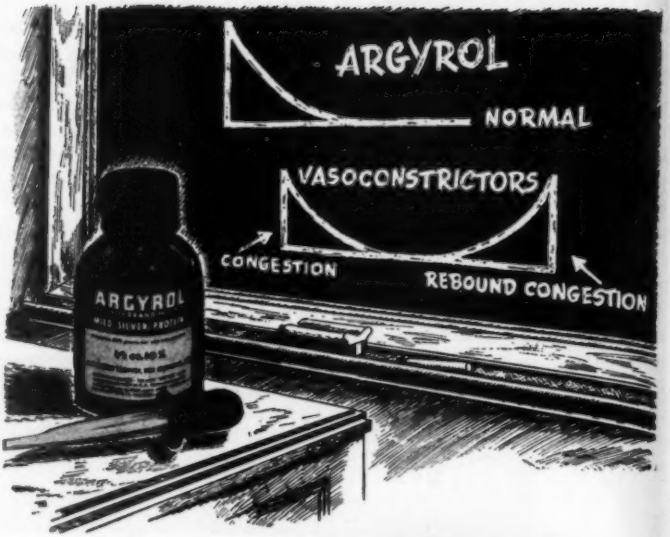
¶ When a newspaper story misrepresented a psychiatrist's position in an ouster suit, a call to the editor was enough to bring an immediate correction.

¶ When a Denver paper wanted a guest editorial on euthanasia, the medical society said it was a touchy subject, but picked a prominent doctor who did a bang-up job.

But cooperation is not censorship. Newspapers continue to publish newsworthy stories that do not always flatter the profession. Colorado doctors make few protests. For they know, says Evan Edwards, that, by and large, their story is being well and fairly told.

Dr. Fred A. Humphrey, president of the Colorado State Medical Society, agrees. He calls the code "one of the most important single steps ever taken by the medical profession. A Denver newsman sizes it up another way. He says the code has only one flaw: It should have been developed twenty-five years ago. END

"Doctor Smithers, would the Oath of Hippocrates forbid you to tell me what Mrs. Peeble's complaint really is?



In Para-nasal Infections **ARGYROL** **provides**

a comeback . . . not a bounce

ARGYROL is bacteriostatic, demulcent, detergent and decongestant—all essential actions. Equally important, ARGYROL decongests without rebound congestion. It does not establish the vicious cycle of Rhinitis Medicamentosa so often associated with vasoconstrictor use.

The ARGYROL Technique

1. The nasal meatus . . . by 20 per cent ARGYROL instillations through the nasolacrimal duct.
2. The nasal passages . . . with 10 per cent ARGYROL solution in drops.
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Its Three-Fold Effect

1. Decongests without irritation to the membrane and without ciliary injury.
2. Definitely bacteriostatic, yet nontoxic to tissue.
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ARGYROL *the medication of choice in treating para-nasal infection.*

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Open Letter From a Doctor's Wife

The lowdown on life in a medical family, as seen from the distaff side

• Dear Doris, Old Chum:

So you're going to marry a doctor! Your letter was wonderful. May I be the first to welcome you into the League of Wives of Perplexing Physicians.

Harvey and I are much impressed with your efficient approach. You say you've purchased a volume on home nursing, polished up your solitaire (smart girl!), and mastered the differences between "itis," "ectomy," and "otomy." You request some pointers on becoming the model medical matron and ask what I, a doctor's domestic dove of long standing, know about doctors –as spouses, that is.

Harvey and I were married eight years and four children ago. Since that time, I have come to this conclusion: Doctors, dear, are lovely but odd creatures. I base my opinion on the following observations.

Whereas Louis the Lawyer or Ivan the Insurance Man may restrict his business life to the hours between 9 and 5 on weekdays (I guess–never having been married to either), the doctor is a twenty-four-hour fellow who eats, sleeps, and breathes medicine. "Sleeps medicine?" you may ask, "but how?" Ed Elger, our young friend who is interning, startled his wife most awfully one night last week. He'd been on surgery service and had gone to bed completely fatigued. Sally woke up at 2 A.M. to find Ed with his eyes shut, his arms outstretched, his hands tensed grotesquely in a claw-like position.

"He's had it," thought Sally. "He wants to strangle me. No! He's having a spasm–a paralytic stroke, perhaps." She jiggled him cautiously. "Ed, what's wrong?"

"Don't shove me," muttered Ed from the depths of some surgical nightmare. "Can't you see I'm holding retractors?"

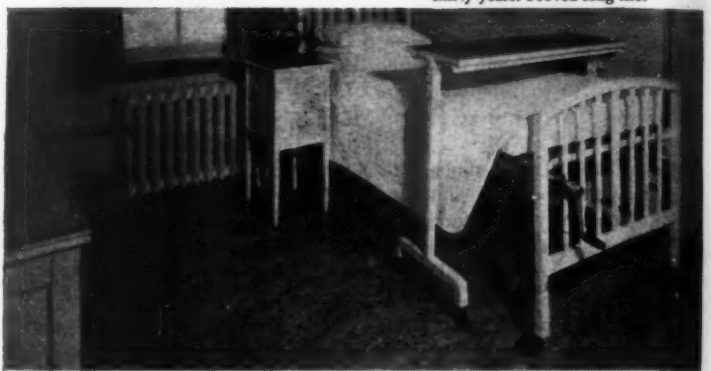
How Doctors Sleep

My own spouse has a few interesting sleeping habits. The bedroom shade can bang all night, the neighbor's dog can yap at the moon for hours, yet Harvey slumbers deeply through all. But let the phone's shrill shriek sound once, and he is awake, alert, and uttering most coherent directions to the sick somebody on the other end of the wire.

[*Turn page*]

you'll see the 4-square features of Nairn Linoleum

1. A corridor in the Hackensack General Hospital, Hackensack, N. J., shows Nairn Linoleum now in use over thirty years. Proved long life!



2. Nairn Linoleum makes this bedroom floor in the same hospital quiet and foot-easy... smooth surface eliminates dirt—and germ-catching crevices . . . insures clean, sanitary floors.

in hospitals everywhere!

Where quiet and long wear are most essential, Nairn Linoleum provides the ideal floor! Its high-quality resilience reduces clatter and the noise of foot traffic . . . insures foot-easy walking for patients and staff alike. Its smooth surface is sanitary and free of germ-breeding crevices. The picture above speaks for itself of Nairn Linoleum's long life. Easily maintained, with no costly refinishing necessary, it assures economical, trouble-free service . . . more floor value for your money.

1. Long Life
2. Enduring Beauty
3. Easy Maintenance
4. True Resilience

For your requirements: Nairn Linoleum Nairn Wall Linoleum Nairn Asphalt Tile Congoleum-Nairn Inc., Kearny, New Jersey

NAIRN LINOLEUM for FLOORS and WALLS

Trademark®

[Pardon the interruption here, Dorey, while I see why our smallest child is screaming . . . . Back now; all is quiet again. The little thing cut his elbow, and we couldn't find tape or gauze or merthiolate. Had to borrow all three from the engineer's wife next door. Lucky thing, her husband deals in heat controls and ventilators; *he* doesn't swipe her medical equipment when she isn't looking. We can't keep a thermometer in our house a week at a time.]

Now, to resume our discussion of the husband-healer:

Table Talk

When I said the doctor *eats* medicine, I referred to table topics. You and I were brought up to speak only of pleasant things at dinnertime—flowers and sunsets and such gentle stuff. Dating from the time Harvey and I were young, unwedded things, I can remember recurrent feelings of bilious nausea when I ate with him and his medical friends. Fatty tumors, coiled intestines, and gangrenous toes might all be ardently discussed while tomatoes, spaghetti, and avacado were being eaten—and the analogy never noticed. My appetite became hardened to this in time, and the children are quite accustomed to it. I sometimes cringe, though, wondering what the little dears say while seated at some alien table.

Doctors, as I observe them, would rather discuss medicine than golf, politics, or sex. They would rather read medical literature than any chronicle of the romantic roistering of the newest historical-novel heroine.

The doctor is also a gadgeteer. Whereas the average man would be satisfied with a metal ashtray for a courtesy gift or bridge prize, the physician loves something complex —like a combination flashlight, can-opener, and tie-clasp. The scientific mind at play, no doubt.

Among the most intriguing things about medical males, to my mind, are the pet theories they impose upon their families. The layman often thinks of the doctor as demanding a sterile world for his wife and children, with never a germ rampant in kitchen or bath. This is not at all true. The physician at home is quite normal about never noticing any of the above. But each M.D. has some special whim.

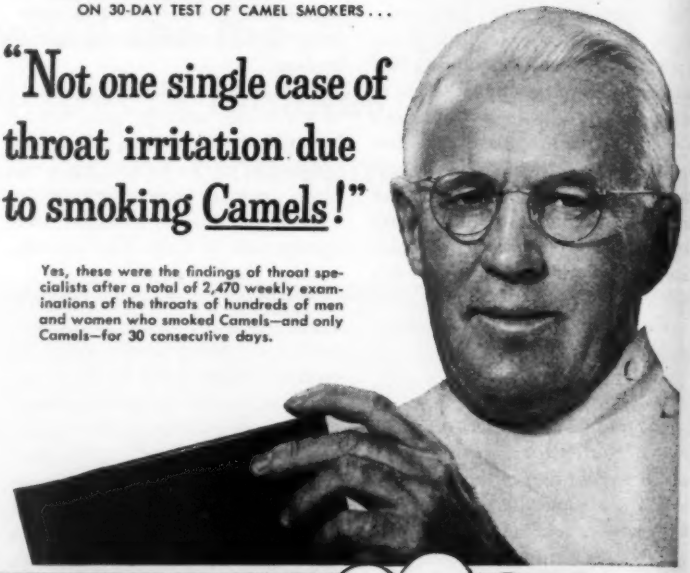
Harvey, for instance, is utter

"I feel much better!"

THROAT SPECIALISTS REPORT
ON 30-DAY TEST OF CAMEL SMOKERS . . .

"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.



R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

ACCORDING TO A NATIONWIDE SURVEY:

More Doctors Smoke Camels

THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

death on the idea of peanuts for children. Peanuts, he says, get stuck in lungs. But George, Harvey's partner, lets his children eat peanuts singly and in whole, chocolate-coated clusters. Yet, he requires these same peanut-filled children to wear high, white shoes until some advanced age when, goaded by the jeers of their fellows, they finally rebel.

The male medico has an amazing resistance to disease. You and the chicks may all be snuffling and fever-fuming, but the doctor usually stays clear-eyed and nasally-normal. You find yourself searching your soul for fear you are neurotic and this cold a purely psychic thing.

Family Falls Ill

But should a gadding germ at last penetrate his magic armor, *then* you have something on your hands! When he is not ignoring his obvious ills and rushing out on a call (sans hat and rubbers), he lies flat on his back and refuses all medication—medication he has gleefully insisted upon inserting into you via teaspoon, dropper, and long, cruel needle. When Harvey and I had been married but a few months, he woke one morning with a vicious cycle of chills and fever. As I hovered over him asking in panic, "What can I do?" he groaned, "Go away. I'm in labor."

In due and proper time after our marriage, as you know, I myself went into labor and produced our first-born. Oh, such a beauty I thought Susie was! When Harvey came into my hospital room, after seeing our child in the nursery down the hall, I waited eagerly for his first words.

"How does the baby look?" I asked tremulously.

Tender were his words, and touching: "It seems to have regurgitated something."

No Pictures, Please

He hates to have his picture taken. He is always being asked for a photo—to accompany forms or to hang in hospitals. Yet he, who has chummed with cadavers and been fearless in the operating room, winces before the professional photographer and his harmless black box. Harvey shocked one photographer most acutely the other day. We had gone to the studio to get proofs of a recent sitting. My husband thumbed through them, then grated: "My God, I look like I'm going through the menopause." I have never been able to hang that particular portrait up since; it *does* have a certain tense and melancholy look.

He is perverse, too, about showing off medically for my female friends when I want to impress them. Dodie Ellis visited us one summer day. Wicked though it is, I do like to have Dodie think my life is a soft, pink cloud, and to have her know my husband for the erudite, suave thing he is.

"Harvey," says Dodie, "I hate to ask you a medical question—off the

FIBERGLAS REPORTS TO THE PROFESSIONS*

Fiberglas Cloth

Used as Backing for Reese

DERMATAPE

(Reg. U. S. Pat. Off.)

(A Skin Transfer Adhesive Tape)

A new technique for obtaining accurate skin grafts is made possible with the Reese Dermatape and the Reese Dermatome†. The technique enables any surgeon consistently and successfully to excise skin grafts from .008" to .034", to tailor the grafts accurately, and to transplant them without stretching or contracting, and usually without suturing.

An important feature of the Reese Dermatape is the backing cloth, woven of Fiberglas yarns.

This is important because:

1—Fiberglas cloth will not stretch.

2—Fiberglas cloth has enormous tensile strength, allowing it to be tightened on the Dermatome without danger of breaking.

3—Fiberglas cloth is impervious to aqueous and alcoholic solutions, permitting adequate sterilization by immersion.

4—Fiberglas cloth securely anchors the rubber splint *during* excision of the skin graft.

5—Fiberglas cloth permits easy separation of the rubber splint and backing *after* excision of the graft, leaving the graft and splint intact for transplantation.

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†Developed by John D. Reese, M.D., Assistant Professor of Plastic Surgery, Jefferson Medical College, Philadelphia, Pa., in conjunction with Irvington Insulator & Varnish Co., Irvington, N. J., and with Lee Tire & Rubber Co., Conshohocken, Pa. Dermatape is used with the Reese Dermatome, manufactured by Bard-Parker Co., Inc. (Agent), Danbury, Conn.

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record like this—but I've had a horrible pain right here (pointing to her rib-cage with a vague but dainty finger). What could it be?"

"Well," says Harvey, "Uh . . . glub . . . muscle . . . uh, old injury of . . . well frankly, Dodie, I don't know. Why don't you ask your doctor?"

At that moment I could cheerfully have jumped up and down on his otolaryngoscope and defiled all his medical books by drawing goatees on the case-history illustrations.

Wife's-Eye View

The doctor, Doris, as I know him, comes home for his evening hug smelling of ether; goes into deep trances pondering on an unprogressing patient, all the while staunchly maintaining he's *not* worrying; spoils his children and thrives on their affection, but would not brag about them outside home boundaries were he bribed with an offer of a deluxe new medical bag complete with built-in X-ray technician.

The doctor is an avid hobbyist, needing desperately to make the most of his limited leisure. He is a perfectionist and he is chronically fatigued. (Jim Hobbs often falls asleep on the living-room sofa and just stays there until operating time the next A.M. Bill Barret's wife is bitter about a lacy black negligee which she bought two years ago and which sleepy Dr. B hasn't noticed yet.)

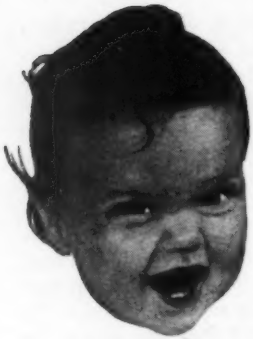
The doctor is a collector. Medical journals of all vintages, colors, and content are hoarded in closet and box. Though he may never look at them again, he seems to derive some warmth and comfort from their nearness. He also collects medical samples, from sulfa syrups to suppositories. But in no logical order does he file these away; so, should his family have sudden need for any medication, the corner drugstore usually supplies the item. The doctor can't find the sample he stuffed away a year ago.

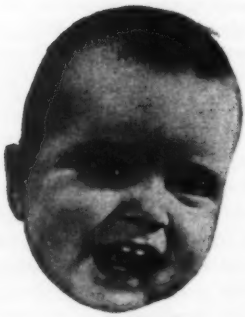
Like all men, the doctor wears terrifying holes in his socks and swathes his head in the newspaper just when you have a most important bit to say. But, unlike other men, the doctor has a special brand of merciful kindness, a lovely sort of universal humor (admittedly sometimes a bit low in type), and unbeatable form while rocking his sick baby daughter out of her pains and aches.

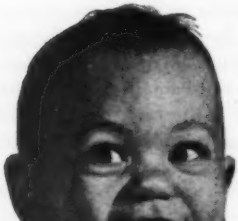
So despite my attempt to show you the blackest side of the profession you now marry into, Doris, take my word for it: Being a doctor's wife is the best, the proudest, and the most rewarding job imaginable.

Love

Ruth, wife of Harvey—and where is he? Dinner was ready an hour ago. The roast will be a shrunken specimen. Shall have to resort to my special cookbook, which I grimly title, "What to Do Until the Doctor Comes." END







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Beech-Nut FOODS *for* BABIES

Babies love them...thrive on them!

What We Can Learn From Cultists

Medical men should borrow three of their techniques, this physician believes

• Whatever charges are leveled at chiropractors and other off-beat yogis of the healing art, one thing we must hand them: They have their share of paying patients. Untold millions of people in this country patronize the cultists and think they get relief. How come?

I've recently had occasion to dig into the literature of these Merlins of manipulation while writing a series of articles for The American Mercury. Out of this has come a conviction that cultists do three things we often don't do—and should.

I

The cultist lays his hands on the patient. Cultists today do what the English monarchy once recognized as a therapeutic procedure. The "king's evil" was once "cured" by the king's touch. Not every case responded, of course, but the laying on of hands often accomplished miracles.

The modern cultist may call it "manipulation," or he may call it "thrust." Basically, however, the first step is the laying on of hands.

In our own lexicon, this can be interpreted as massage, or even as physiotherapy. How often has massaging a patient's neck relieved spasm of the cervical muscles and an associated headache? How often has massaging a patient's back relieved fatigue and induced sleep?

We physicians think we invoke *every* method that can help the patient. Often, however, we put too much stress on our pills and capsules, our analgesics and sedatives. Our limited use of physiotherapy, perhaps more than anything else, explains the rise of unorthodox healers.

II

The cultist makes good use of psychology. In doctors' rooms at hospitals, one often overhears this lament. Usually it's implied that psychology is something that the cultist needs but that is unnecessary for the orthodox practitioner. But does any doctor believe that psychotherapy should be a monopoly of the cultists?

If the laying on of hands is important, so is the laying on of the mind or the heart or the soul. What pill is effective for the woman who

is tired because her husband drinks? No remedy is as effective in such cases as psychotherapy. If the physician does not provide it, the patient will turn to the cultist.

III

The cultist speaks the patient's language. Chiropractors, for example, often make clear to the patient some of the most abstruse problems in physiology. They do this simply by ignoring blood vessels, the endocrine system, and complex problems of physiological chemistry. They merely discuss the body in its mechanistic concepts.

Why can't *we* do this? We can. It's often a good idea to use mechanical analogies in describing disorders. After examining one patient recently, I told him: "You are a fortunate man. The Lord endowed you with a Cadillac for a body. The only trouble is, you don't know how to drive it. You are racing around with your accelerator down to the floor and with your hand-brake on. No car, no matter how good it is, works well if driven that way. No human being gets along well if he is racing full speed ahead and doesn't release the brake."

Even if the analogy is inexact, it will help the patient understand. You'll find it quite easy to think up useful analogies. The spine is nothing but blocks placed one above the other. The heart is a big pump. The eye is a camera The blood vessels are steam pipes or water pipes.

Don't get the idea that I think cultists should be encouraged. Far from it! But I do think we can pick up a few lessons from them, for the greater benefit of our patients. If these three rules could be universally taken to heart, medical cultists would soon disappear.

—JOSEPH D. WASSERSUG, M.D.

Men of Science

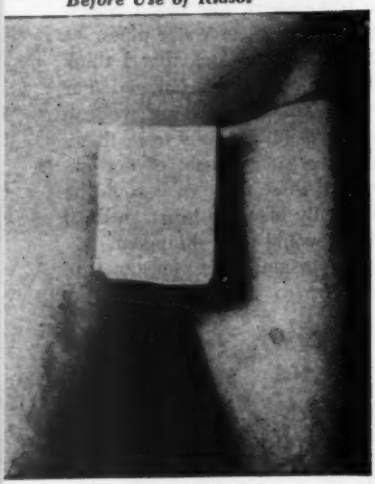
IV

A gynecologist must be
Possessed of equanimity—
Not even stirred by Aphrodite
Enveloped in a silken nightie.

A paragon of poise and tact,
Yet scientifically exact;
Hippocrates to womankind.
(A braver man you'll never find!)

—ALICE MARTIN LESTER

Before Use of Riasol



After Use of Riasol

PSORIASIS ha

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until he resorts t

RIASOL

Many a doctor groans with disma when he sees a patient with psoria Even dermatologists admit th psoriasis is exceedingly resistant t treatment.

Recent clinical investigations ha proved, however, that RIASOL clear improves the ugly skin patches of psoria in 76% of cases. Often there is comple disappearance of the cutaneous lesions wi prolonged remissions.

RIASOL actually reaches the corium a the deeper layers of the epidermis. I therapeutic action is evidenced by gradu fading of the red patches and disappea ance of the accumulated silvery scales.

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RIASOL FOR PSORIASIS

The Newsvane

Good Defense May Reduce Atom Bomb Casualties

Doctors who want the ounce of prevention—adequate civilian defense—are quoting W. Stuart Symington, chairman of the National Security Resources Board: "It is estimated that with only twelve minutes' warning, as against no warning, and under efficiently planned civilian defense, the casualties in a city hit by an atomic bomb could be reduced 50 per cent."

Turning to the pound of cure, Drs. Norvin C. Kiefer and Robert H. Flinn of NSRB's Emergency Medical Services say, "Some idea [of what's needed] can be gleaned from the estimate that first-aid and surgical supplies for the first week following an atomic bomb disaster comparable to that at Hiroshima would fill 200 railroad box cars."

Potential Nurse Loss Worries Hospitals

As mobilization got under way, hospitals throughout the country began to fear that the nurse shortage, already acute, might become critical. During the summer, New York City had a foretaste of what may come, when a number of its hospitals had to shut down wards and sections. Reason: Nurses were on vacation and no replacements could be found.

One cause of the shortage, say administrators, is New York State's new nurse practice act, which forbids employment of any nurse until she is licensed. Yet some institutions have deliberately flouted the regulation. Said one hospital superintendent: "If a girl walks in here and says she's a nurse, she'll get a job—license or no license. That can come later. Our first job is to care for the sick."

Hospitals' Profit on M.D.'s Ruled Taxable

Voluntary hospitals may not profit from the work of salaried doctors and expect that profit to be exempt from taxation, says the Ohio Supreme Court.

Some time ago the Cleveland tax board reported that the Cleveland Osteopathic Hospital had engaged a number of doctors on salary and had netted a taxable profit of $111,007 on their work in 1948. While the practitioners were paid about $12,000 a year for having given up their practices to treat patients in the hospital, the institution col-

lected relatively more than that in fees.

In its appeal, the hospital claimed it was a nonprofit institution that took in some charity cases, so its income was not taxable under the law. Rejecting this idea, the court said, "Where a hospital extends its facilities and services very largely to those who . . . pay the established rates . . . and designedly makes a very substantial profit in so doing, it places itself in the classification of a business enterprise . . . notwithstanding that some unfortunate persons without means are cared for free of charge."

Gives Economic Picture Of G.P. Academician

The average gross income of members of the American Academy of General Practice is $20,800, reports Mac F. Cahal, AAGP executive secretary. This, he says, is "consider-

Cartoons

¶ The caption for the cartoon on page 135 was contributed by a practicing physician. Can you think of a gag line for this cartoon or for any other captioned cartoon in this issue? MEDICAL ECONOMICS will pay $10.00 for each caption accepted, or for any original cartoon idea with a medical slant. Address Medical Economics, Rutherford, N.J.

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ably higher than the average for all general practitioners, which, according to the Sixth MEDICAL ECONOMICS Survey, was $15,953."

Mr. Cahal's report, based on a sampling of academy members, reveals that the average member is 41 years old; has been in practice 15 years; lives in a city of 50,000-100,000 population; sees 25 patients every 11-hour working day; spends 40 per cent of his income for professional expenses; has a net of $12,480; and devotes five hours a week to charity cases. Drugs and clinical equipment cost him $2,600 a year; office equipment and instruments, $940.

"The average member," says Mr. Cahal, "belongs to the active medical staff of at least one hospital—only 3 per cent have no hospital affiliations. Fourteen per cent handle no obstetric cases, but the average man delivers 44 babies a year."

The average member also performs 64 surgical procedures yearly" and "is to some extent engaged in industrial practice, treating 234 such cases each year."

Don't Profit on Drugs, Physicians Warned

Dispensing physicians who profit on drugs are giving themselves and the profession a black eye. So says the Bronx County (N.Y.) Medical Society, which reports a "disturbing" number of complaints. It warns that drugs must be charged for at actual cost, since the doctor makes his profit out of his fee. Singling out penicillin as an example, the society says that while it was once an expensive drug it is no longer so, and the public "keeps well informed on such matters."

FSA Rapped for Waste and Inefficiency

"Administrative indecision . . . lack of fixed responsibility and authority . . . faulty budget structure . . . uncontrolled personnel practices . . . overstaffing . . . inefficiencies . . ."

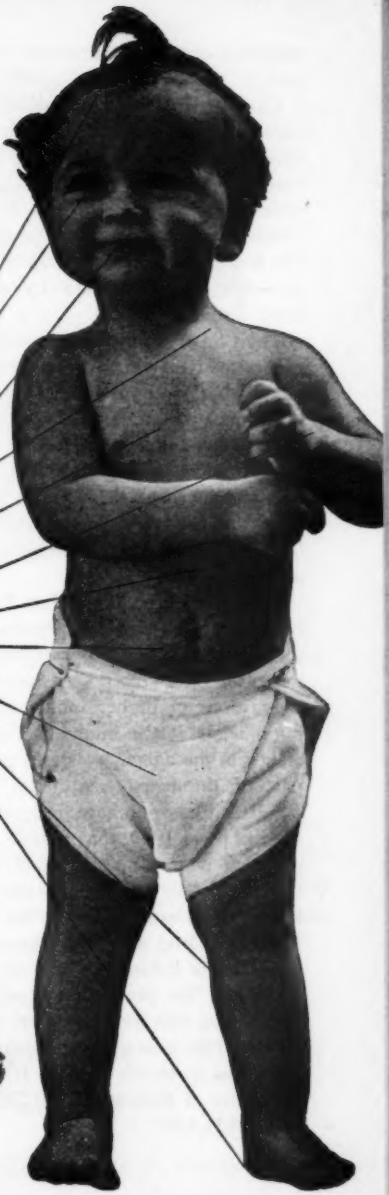
These are some of the key charges leveled against the Federal Security Agency by the House Committee on Post Office and Civil Service, following a detailed investigation reported in part last month (Aug. MEDICAL ECONOMICS, page 57).

The committee scores the FSA for having no clear lines of responsibility. "Reluctance to exercise central authority," it says, has brought about "jurisdictional conflict, duplication of effort, [and] empire building."

To the portrait of many tails wagging one dog, the committee adds a sketch of jealous executives bickering among themselves: "Major differences of opinion were found to exist between the people engaged in the various specialized programs and the administrative leadership; between civilian and commissioned officers; among the advocates of centralization versus the proponents of decentralization; and between

from *head* to *toe*

CEREVIM-fed children showed greater clinical improvement, in the following nutrition-influenced categories, than children fed on ordinary unfortified cereal or no cereal at all:[1]



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1. "A Study of Enriched Cereal in Child Feeding," Urbach, C., Meck, P. B., and Stokes, Jr., J.: Pediatrics 1:70, 1948.

*Cerevim contains neither vitamin A nor C, but apparently exercises an A-and-C sparing effect attributed to its high content of predigested protein and major B vitamins.

employes engaged in line and staff work."

These cliques, the committee adds, "exercise potent influences which, in the end, determine the form of internal organization and, more important, the manner in which the organization is managed. The inevitable result is confused responsibility accompanied by diffused authority."

The FSA not only has "too many administrative layers," says the committee, but many of them overlap to a major extent. This costly and unnecessary duplication, it says, extends from the Office of the Administrator right down through the "administrative level" (executives of USPHS, SSA, etc.) into the bureaus and field offices.

The committee finds that FSA funds are allocated to projects in such a manner that program directors often have veto power over the suggestions of higher, policy-making officials. It also finds that inefficiency in the agency wastes a good part of the taxpayer's dollar: Of 121,014 FSA purchase orders issued in fiscal 1949, for example, 50 per cent were for amounts of less than $20. Yet the average cost of issuing each order was $5. "In the Food and Drug Administration and the Office of Education," the report continues, "the proportion of orders under $20 was more than 60 per cent, and the average cost of issuing each was in excess of $10. It cost the Office of Education $10,293 to spend $31,148."

"Many, if not all, these shortcomings and discrepancies are known by the key officials," the committee declares. "Some . . . are wary of making decisions that will reduce employment or incur the ill will of a colleague . . . Others are evasive and tend to defend the prevailing circumstances regardless of the preponderance of evidence. [A majority] admit that most of the charges are valid. They . . . realize that there is no organized effort toward improvement of these conditions from within."

Watered-Down UMW Medical Plan Begins

The medical service program of the United Mine Workers, suspended last September when funds from the 20-cent-a-ton coal royalty ran short, was again put into operation a month ago. But it was a long cry from the original. For example:

¶ Excluded from benefits are all miners and dependents who hold prepayment insurance or who can get Government aid (*e.g.*, veterans).

¶ The insured get no benefits for home or office calls, only for treatment in hospitals.

¶ No obstetrical care is given except in hospitalized cases.

¶ Dental care is likewise excluded unless part of hospital treatment.

¶ No refractions are provided except in connection with eye surgery.

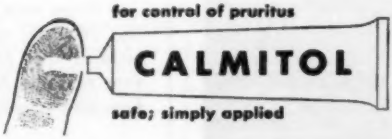
¶ Only by special authorization

pruritic puzzle

Etiology is enigmatic and signs may be imperceptible in anogenital pruritus. But the itching is pronounced and relief imperative.

antipruritic answer

Promptly upon application, Calmitol Ointment gives the patient relief. Most important, Calmitol Ointment is safe in use since it contains neither phenol (as in calamine with phenol) nor cocaine or cocaine derivatives.



Active ingredients:
Camphorated chloral
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are specialist services provided.

Net result: John L. Lewis's UMW, which has long deplored the "limited services" of doctors' prepayment plans, now has a lulu of its own to peddle to members.

Prepay Plans Hit for 'Neglect' of Chronics

Oscar Ewing and the AMA, in their jousting over health insurance, both dodge the major issue of chronic illness, says the Detroit Free Press, a consistent opponent of nationalized medicine. Voluntary insurance is on the upswing, says the newspaper, thereby minimizing the need for compulsory health insurance; "but voluntary plans offer no relief to the person who needs assistance most: the victim of chronic illness."

Such people, says the Free Press, are "the tragic victims of forgetfulness and neglect. The Fair Dealers nod to them in passing but do not stop. The AMA does little better. The victim . . . may face a lifetime

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.

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Standard Set, Catalog No. 1106

STANDARD SET comprises ophthalmoscope head (with built-in color filter and aperture changer), otoscope head with 3 specula, medium battery handle and one spare lamp, in plush-lined case, with space for additional specula and tongue depressor.

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Large Set, Catalog No. 1109

LARGE SET contains otoscope head, 5 ear and 1 nasal specula, ophthalmoscope head (with built-in color filter and aperture changer), large battery handle, 1 extra lamp, with provision in case for tongue depressor head, additional specula and lamp replacement.

PROFESSIONAL SET. This, the most complete Wappler set, incorporates an otoscope head with 5 ear and 1 nasal specula, tongue depressor head, ophthalmoscope head (with built-in color filter and aperture changer), large battery handle, extra lamp, and rubber bulb for insufflation.

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of hospitalization. And there is no insurance available to him . . . Deep in their hearts, the American people fear, most of all, the horror of chronic illness. By preying on that emotion, the socialized medicine advocates have made their real appeal. Yet they offer nothing in the way of security and hope.

"Neither does the medical profession. It is time somebody did!"

Societies Woo Public in Diverse Ways

Progress in public relations:

¶ The grievance committee of the Onondaga County (N.Y.) Medical Society is not only willing to hear patient's complaints but is inviting them in newspaper advertisements.

¶ The Minnesota State Medical Association is going along with a trend by opening all its meetings (except executive sessions) to newspaper reporters.

¶ The Vanderburgh County (Ind.) Medical Society says it "has quit talking about public relations and is doing something about them." That "something"—a number of community-service projects—is described in leaflets distributed to patients.

G.P. Called Best Doctor For Most Persons

"Pick yourself a family doctor before you need one. He may mean the difference between life and death." That urgent message was placed before millions of readers of

NEW FORMULA: Johnson's Baby Lotion has been newly formulated with hexochlorophene 1%. Result: it has demonstrated itself to be a specific preventive and therapeutic agent for five common skin afflictions of infancy: impetigo contagiosa, miliaria rubra, cradle cap, excoriated buttocks, and diaper rash.

NEW EFFECTIVENESS: To authenticate the effectiveness of this new formula, Johnson's Baby Lotion was subjected to clinical investigations in 8 leading hospitals for more than 10,000 cumulative baby days. Records show that it reduced the incidence of skin irritations of all types to an average of less than 2%.

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JOHNSON'S BABY LOTION

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Mail coupon for 12 distribution samples of new Johnson's Baby Lotion.

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Offer limited to medical profession in U. S. A.

the Woman's Home Companion a month ago in an article entitled "The Best Doctor for You."

"In Indianapolis," the article reports, "a big department store asked its 3,000 employes if they had family doctors; 80 per cent said no. The medical society in Indianapolis gets about 12,500 calls a year from people who have no doctor and need one in a hurry . . . It is estimated that at least half of all Americans are in this hazardous position."

Nation's Health Lobby Irked by AMA Zeal

With a lump in its throat, the Committee for the Nation's Health has broken the news to members that the AMA is determined to keep up its "political activities" and "lobbying" in an effort to defeat compulsory sickness insurance. "It is sad," mourns the committee, "that such negative and reactionary policies are put forward officially as the position of a great profession dedicated to human service."

The committee, itself a lobbying organization, is shocked, but not to speechlessness, by the AMA decision to advertise its position in 11,000 newspapers, 30 magazines, and 300 radio stations next month (Oct.). "The same policies," it says, "are reflected in recent efforts of the AMA Washington lobby to defeat extensions of Social Security, to block Federal aid to medical education, school health services, and other measures, and the failure . . . to take a positive stand in behalf of

NEWS ABOUT A BAUER & BLACK PRODUCT

Shouldn't an elastic bandage, Doctor, be truly elastic?

TENSOR contains live rubber threads—provides pressure without binding

A *Tensor* Elastic Bandage gives a wider range of pressure—a more exact control of pressure—than the conventional *rubberless* elastic bandage.

The latter depends entirely on the weave for elasticity. The *Tensor* stretches to twice its length because of its *live* rubber threads. Doesn't lose elasticity even over a long period. Maintains proper tension, provides greater mobility, and frequent adjustments are not needed.

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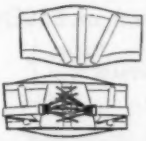

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any national health legislation, even such a bill as Senator Taft has proposed.

"The AMA has given no support to bills which would increase Federal aid for medical research. The AMA has done its utmost to defeat the bill for Federal aid to medical education passed by the Senate last year. This year it [the bill] has been held up in the House Committee on Interstate and Foreign Commerce by delaying tactics instigated by the AMA [which] has not dared to take a public stand against the bill, possibly because it would risk an open break with prominent physicians and deans of medical schools who favor the bill and believe that freedom of the schools is fully protected by its provisions."

As if this weren't enough, the committee is haunted by the fear that AMA public-relations mercenaries may set up a vast political machine "to fight the whole Fair Deal and to oppose every progressive candidate in his own state or district."

Calls for Tax on Blue Shield, Blue Cross

Exempting Blue Shield and Blue Cross plans from taxation puts "a penalty on private enterprise and encourages state socialism," says the Mississippi Valley Medical Journal. The journal indorses the view of insurance men that Government planners favor exemption for voluntary plans because they hope to take

THE B-D YALE ANEROID MANOMETER

Jeweled Bearing

We've borrowed from the watchmaker's craft to give you a Jeweled·Bearing sphygmomanometer for greater accuracy and durability. Uniformly-spaced scale graduations for easy reading; long-travel beryllium copper bellows for longer life; detachable inflation system with the new B-D SECURITY CUFF (hook-type) for greater convenience and flexibility. *Guaranteed indefinitely* against all defects in material or workmanship.

See it at your dealer's . . . look for the red dot on its face . . . it identifies the Jeweled·Bearing B-D YALE ANEROID MANOMETER.

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.

them over some day. It adds that "The Government is constantly trying to plug income-tax leaks but is missing a real stream . . . This loss of revenue must be made up by the rest of us, hence our income taxes are increased proportionately." The journal favors voluntary prepay plans, but thinks they should be put on the same basis as commercial companies, which pay millions in taxes each year.

Doctors' Story Being Told at Colleges

A campaign to set college students straight in their medical-economic thinking has been launched by Lawrence Rember, director of the AMA public relations department. AMA speakers appearing before college audiences can do much to change misconceptions of the medical profession, Mr. Rember believes.

College students are highly receptive to social propaganda, good or bad, he emphasizes. Being idealists, they "find it easy to accept the recommendations of the social planners that we revolutionize our social, economic, and political ways for improving America."

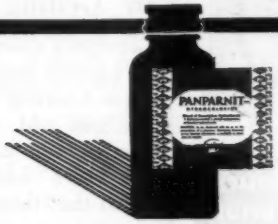
Up to recently, says Mr. Rember, such students got no facts from the medical profession, and were inclined to swallow whole the derogatory attacks made upon it by Government officials.

Students addressed so far have shown keen interest in such things as the Truman health plan, the British medical system, voluntary pre-

a major step
in rehabilitation of the
parkinsonian patient

PANPARNIT T.M.

Known previously to investigators as PARPANIT.



Treatment of the Parkinsonian syndrome with PANPARNIT was observed by Schwab and Leigh[1] "to be superior to the previous medication" in 65% of cases. With a careful regimen of gradually increasing dosage, "very satisfactory results with this new compound will follow."

By reducing rigidity and tremor PANPARNIT frequently enables the Parkinsonian patient to resume a more nearly normal life . . . to perform simple daily tasks, to feed, to shave, and to dress himself. Improvement of physical status leads to increasing self-reliance and a happier frame of mind—a major step toward mental as well as physical rehabilitation.

A totally new synthetic drug, PANPARNIT offers the advantages over the belladonna alkaloids of frequently affording more satisfactory relief and rarely causing disturbances of vision or dryness of the mouth.

1. Schwab, R. S. and Leigh, D.: J.A.M.A. *139*:629, 1949.

Geigy

Fuller information regarding clinical studies and suggested dose schedules will be furnished gladly.

PANPARNIT (caramiphen hydrochloride): Available as sugar-coated tablets 12.5 mg. (bottles of 100) and 50 mg. (bottles of 50, 250 and 1000).

GEIGY COMPANY, INC., 89-91 Barclay St., New York, N. Y.

payment insurance, availability of doctors at night, high fees, the distribution of M.D.'s in rural areas, D.P. physicians, and the participation of doctors in community affairs.

Mr. Rember hopes his speakers will appear especially before journalism classes, he says, "when these students leave the campus they go o work as opinion molders on newspapers, magazines, radio stations," and other publicity media.

Mother-Infant "Rooming In" Getting Popular

Grandma's system—mother and baby together in one room—is booming in American hospitals, the AMA has been told. After try-outs in a number of institutions over the last few years, doctors who first opposed the "throwback" system are now its enthusiastic supporters. It is, says Dr. Crawford Bost of San Francisco, "doing what comes naturally."

The aseptic, behind-glass segregation of infants is being ended, says Dr. Angus M. McBryde, of Duke University Hospital, Durham, N.C., because it is no longer needed. The mother-and-babe-together system is compulsory in his hospital, whether the patient can afford a private room or must be content with an eight-bed ward.

Much is gained with little risk, says Dr. McBryde. Mothers take great comfort in having their babies in the room—or in the bed—with them. Moreover, they and their husbands quickly learn how to care for

A New Pleasant Tasting—

BACITRACIN TROCHE

WITH BENZOCAINE

FOR CONTROL OF LOCAL DISCOMFORT

The clinical efficacy of bacitracin troches has been further expanded by the incorporation of 5 mg. of benzocaine per troche. The local anesthetic action so provided, in addition to the specific antibiotic effect of the bacitracin, makes for a wider field of usefulness in the treatment of pharyngitis, tonsillitis, and gingivitis. These troches remain intact for a prolonged period thereby exerting an extended anesthetic influence and creating high salivary bacitracin levels.

The confection-like chocolate taste of C.S.C. Bacitracin Troches with Benzocaine makes for universal patient acceptance. Their candy-like taste and appearance encourage their continued use by adults as well as by older children.

C. S. C. Bacitracin Troches with Benzocaine are available on prescription through all pharmacies in bottles of 25.

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Each C.S.C. Bacitracin Troche with Benzocaine contains
1000 UNITS OF BACITRACIN AND 5 MG. OF BENZOCAINE

the infant by watching the nurse attend it.

Ordinary precautions—washing of hands and exclusion of communicable diseases—prevent infection, he adds. Of 1,862 babies "roomed in" with their mothers at Duke, only five developed infections.

Army Medical Corps Has 175th Anniversary

The Medical Department of the Army has just celebrated its 175th anniversary. The fifth oldest military service, it got its first taste of war in the Boston Massacre of 1775. A group of doctors on that hot July day rushed to the aid of the wounded, and thereafter were considered part and parcel of the Revolution. That same month, the Continental Congress approved plans for a "hospital," by which it meant a medical department, and not a building.

From then on, says the Army, there was no stopping its medical men. Witness:

In 1775, John Jones, an Army surgeon, wrote the first American textbook on surgery.

In 1800, Benjamin Waterhouse, another surgeon, introduced vaccination to the U.S.

In 1814, Dr. James Tilton, Surgeon General, started the first meteorological records in America. The same year Dr. Albert J. Myer founded the Weather Bureau *and* the Army's system of signaling.

Later on . . .

Surgeon General George M.

PREVENTION OF RECURRENCES
A REPORT OF 125 PEPTIC ULCER PATIENTS

While the immediate relief of symptoms in a peptic ulcer patient is desirable, occasionally more important is the duration of the effect—i. e. the absence of recurrence. Stimulated by the work of Ivy with mucosal "resistance raising" substances, workers have reexamined the value of mucinous substances, in the treatment of peptic ulcer.

PROCEDURE

125 Patients suffering from gastroduodenal ulcer for from 3 weeks to 40 years were divided into 2 groups. The first group includes 105 patients who were started on the new therapy because of an exacerbation or recurrence of symptoms. The second group includes 20 patients, designated as intractable, because they did not respond to a previous medical regime. All patients were placed on medical management. All patients received a bland diet, with milk and cream with meals and between meals. No night feedings were permitted. The majority of the patients were placed on 2 to 4 Mucotin tablets 1 hour before meals, 1 hour after meals and at bedtime. In patients with severe symptoms, hourly doses of Mucotin were given. Night pain was controlled by Mucotin only.

RESULTS

Immediate Effect. The majority of patients were relieved of symptoms in the first 7 to 10 days of treatment. Of interest is the group of 20 cases with previously "intractable" ulcer symptoms which responded to Mucotin.

Late Effect (Prevention of Recurrences). 89 patients had been on a treatment from 12 to 20 months; 28 patients from 9 months to a year; and 8 for less than 9 months.

Of the 89 patients under treatment for more than 1 year, 53 had complete relief and no recurrence. Of the remainder, 8 had slight to moderate recurrences following emotional upsets — 4 had partial relief; 12 admitted dietary indiscretion, 2 of these had food allergies and 3 milder seasonal recurrences; and in 12 patients the cooperation was poor.

Of the 28 patients under treatment from 9 months to a year, 26 had complete relief and no recurrence. The 8 patients under treatment for less than 9 months all had prompt relief the first week and no recurrence to date.

We were impressed with the results in the group of "intractable" ulcer patients. Patients who did not improve on other antacids responded quite promptly when Mucotin was substituted. There seemed to be a more rapid rate of healing as noted from the prompt decrease in size of the gastric ulcers. This might have been due to the coating effect of Mucotin. Mucotin has also proven to be a good substance in preventing recurrences.

SUMMARY

This substance led to rapid clinical improvement during the stage of exacerbation and also apparently prolonged the pain-free intervals, having a recurrence rate of 15 to 18% in 12 to 24 months respectively.

—HARDT AND STEIGMANN Am. Jour. Digest. Dis. 3: 195-202, June, 1950

A complete reprint of the Hardt and Steigmann report will be sent on request.

Name_____

Address_____

City_____ Zone___ State_____

31-66-6B

Sternberg discovered the micro-organisms of pneumonia, pioneered in bacteriology, established the Army Medical School, and organized the Army Dental Corps and Army Nurse Corps.

Dr. John S. Billings revolutionized ventilation in hospitals.

Major Walter Reed and his associates beat yellow fever.

Major Carl R. Darnall invented the first apparatus for liquid chlorination of water.

In recent years, the Army Medical Department has . . .

Indicated that rheumatic fever may be prevented by treating with penicillin the streptococcic disease which precedes most cases of acute fever.

Developed, since World War II, more prosthetic appliances than had ever been invented before.

Produced the healthiest Army in history (1939 death rate from disease: 1.55 per 1,000 men; 1949 rate: 0.53).

Developed extensive information on the management of burns.

Caution Merchants and M.D.'s on Rebating

An all-out drive against kick-backs or rebates has been started by the Cincinnati Academy of Medicine in cooperation with the local Better Business Bureau. Each physician member was recently notified by letter that the practice had been adjudged unethical by both AMA and academy codes, and that it would not be tolerated in Cincin-

nati. The acts of "a small minority" of doctors, the academy says, have created enough resentment against the profession to warrant "forceful action to abolish this evil."

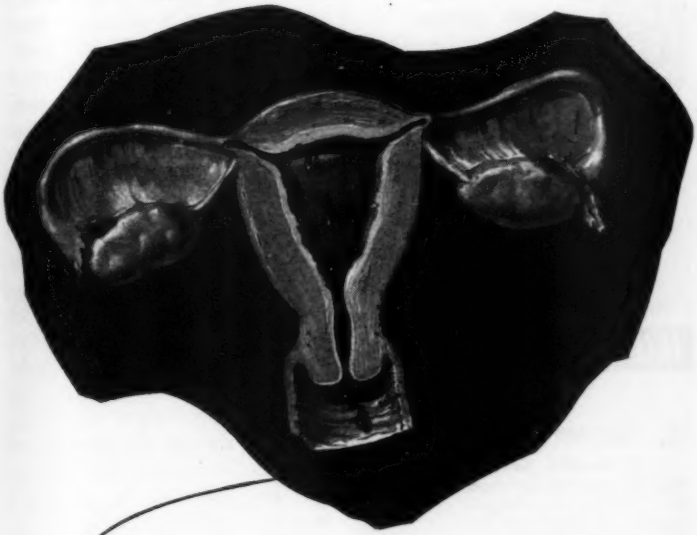
The Better Business Bureau has drawn up a "code for merchants," under which retailers agree not only to cease rebating but to keep their books open for bureau inspection at any time during business hours. In return, each merchant gets a plaque for public display, signifying his compliance with the code.

Doctors Avert Boxing Deaths in New York

The high incidence of accidental deaths and serious injuries in the prize ring has long disturbed public officials. Can it be reduced, they have asked, or will public revulsion eventually bring an end to professional boxing? One encouraging sign: In the first six months of 1949, ten boxers here and abroad died from ring injuries. During the same period of 1950, only one succumbed. How did this come about?

Through preventive medical measures, says Dr. Frank R. Ferlaino, of Manhattan. The doctor is chairman of the medical advisory board of the New York State Athletic Commission. This nine-physician board has already chalked up an impressive record by catching before it was too late many a latent condition that might well have caused serious harm. "We can't

Stop excessive uterine bleeding!



Functional uterine bleeding is most common in patients approaching the climacteric or during adolescence but it may occur at any age. Usually it is menorrhagic in type, but it may be intermenstrual or metrorrhagic. There may be complete irregularity in the menstrual function.

Anti-Menorrhagic Factor Armour

is recommended in all these varieties provided there is no underlying organic factor such as tumor. The active anti-menorrhagic factor from sterols of the liver is of marked value in the control of functional uterine bleeding.

Dosage: During excessive flooding, massive dosage—8 or more glanules t.i.d., up to 50 per day. Best time to start treatment is about 2 weeks before menstruation, 2 or more glanules t.i.d.

ARMOUR *Laboratories*

Have confidence in the preparation you prescribe—specify "Armour"

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

prevent all injuries or fatalities, but we can reduce them by seeing that each boxer is in good physical condition before entering the ring. And we can step in and stop a bout if we think a man is taking too much punishment for his physical good.

"In the old days," says Dr. Ferlaino, "boxers were given cursory, pre-fight examinations in a bare room of the arena." Now the picture has changed completely. Thorough examinations are made using all the most modern equipment.

Before he can get his annual license, each New York boxer or wrestler must undergo such an examination. Complete records are kept of his condition. Five days before each major fight, he gets another check-up; and at weighing-in time the day of the contest, still another. Meantime, he must report any injury he has suffered in training.

A physician is present at every fight, with full authority to examine the contestants between rounds and to order the fight ended if he decides a man is not in condition to continue.

Over a recent period, the commission's doctors found three cases of partial blindness, and sent the boxers to specialists for care. They also discovered three hernias, requiring surgical correction, and twenty cases of cardiac murmurs, five showing definite evidence of heart disease. The boxers were advised to give up the ring, as were four others with abnormal electroencephalograms.

Index of Advertisers

CASE: 16*

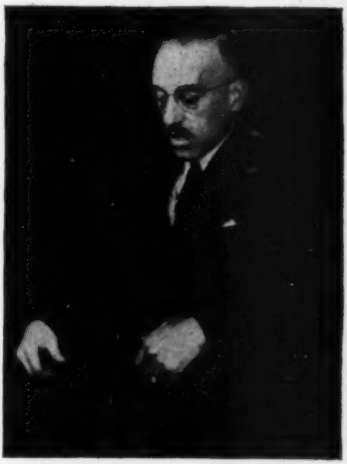
54-year-old man suffers severe parkinsonism of seven years' duration. Symptoms unrelieved by scopolamine hydrobromide, but treatment with* RABELLON *Compound of Belladonna Alkaloids provides marked benefit.

G. T., a 54-year-old man, had been suffering from severe parkinsonism for seven years. For the last five years he had been taking 5.0 mg. of scopolamine hydrobromide daily.

Despite this therapy, severe symptoms of parkinsonism persisted. These included sialorrhea, hyperhidrosis, restlessness, depression, marked tremor and rigidity of the extremities, loss of associated movements, masked facies, slow gait and retropulsion.

Moreover, the patient was unable to write, button his clothing or wind his watch, and was frequently unable to eat without assistance. He had not worked for the last three years.

After examination by his present physician, it was decided to change treatment. For the next 20 days scopolamine hydrobromide was gradually withdrawn and replaced by smaller doses of RABELLON Tablets Compound of Belladonna Alkaloids, 4.0 mg. daily.



Note characteristic posture of hands and fingers, the "pill rolling" movement. Slightly flexed head and masklike features are characteristic of parkinsonism.

On this new therapy the patient's improvement was marked and rapid. He was soon able to eat without assistance, write, button his clothing, and wind his watch. Rigidity, muscle pain, hyperhidrosis, salivation and restlessness were greatly diminished. Gait, tremor and general spirits were much improved.

No toxic effects from RABELLON Tablets were experienced except for occasional slight dryness of mouth. The patient reported he felt "50 to 75 per cent better," and spoke of returning to his old job.

*Actual case record

Are you taking advantage of this Free Ivory Handy Pad?

"INSTRUCTIONS FOR BATHING YOUR BABY"

This convenient time-saving aid is now being used by thousands of doctors. It provides a quick and effective way of giving the young mother required routine instructions for bathing her baby.

Each of the 50 printed leaflets in "Instructions for Bathing Your Baby" contains text and pictures explaining the approved methods for bathing infants. Ample blank space at the end of each leaflet is provided so you can write your own additional instructions, when necessary. Thus, you can give mother the necessary guidance—in easy-to-consult form—simply by handing her a leaflet.

5 Different Ivory Handy Pads, Free

"Instructions for Bathing Your Baby" is one of five different Handy Pads developed for you by Ivory Soap. The subject of each Handy Pad is designed to meet a definite need in practice. There is no controversial matter in the entire series; only professionally accepted routine instructions are included.

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YOU CAN OBTAIN—FREE—ANY OR ALL OF THE IVORY HANDY PADS

Write, on your prescription blank, to

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Ask for the Handy Pads you want by number. No cost or obligation.

No. 1: "Instructions for Routine Care of Acne."
No. 2: "Instructions for Bathing a Patient in Bed."
No. 3: "Instructions for Bathing Your Baby."
No. 4: "The Hygiene of Pregnancy."
No. 5: "Home Care of the Bedfast Patient."


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